STATE TITLE V BLOCK GRANT NARRATIVE
STATE: AK
APPLICATION YEAR: 2005

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Commissioner of the Department of Health and Social Services signs the Title V application with the required Assurances and Certifications attached for reference. This information is kept on file in the Division of Health Care Services, 4501 Business Park Blvd. Anchorage, AK 99503.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A public notice informing the general public that Alaska's Title V Block Grant application was available for review was posted to the state's on-line public notice system on June 15, 2004. In addition, several key stakeholders and partners were individually contacted and provided the opportunity to review the application. These agencies included: Alaska DHSS Public Health Nursing, Alaska DHSS Primary Care and Rural Health Unit, All Alaska Pediatric Partnership, March of Dimes, Dept of Education and Early Development, Governor's Council on Disability and Special Education, Early Intervention and Infant Learning, Division of Senior Services and Developmental Disability. Four requests were received for copies of the block grant application. No comments were received from the public or any of the agencies or programs who requested a copy of the block grant.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The Division of Health Care Services now contains some of the programs orginally part of the Section of Maternal, Child and Family Health (MCFH). This division administers the State of Alaska's Title V funds, provides health services and support to families, child-bearing women, and children with special health care needs (CSHCN). Some of the MCFH programs operate out of the Division of Health Care Services as part of the Alaska Department of Health and Social Services. Other programs that had been a part of MCFH reside in three other divisions of the Department of Health and Social Services including the Divisions of Public Health, Behavioral Health and Public Assistance. While there are numerous factors that influence the way in which both MCFH and its many programs operate, a synopsis of four which will have or are perceived to have, the greatest impact on operations in the next year are included below.
/2002/ Alaska's health care system differs from most other states in that there are virtually no local health departments that function under the umbrella agency of the state health department. Two communities have locally organized health departments - Anchorage and the North Slope Borough. In addition to these two local health departments, the entities operating in Alaska to deliver health care services include: the Department of Health and Social Services; private physicians and other health care providers; private hospitals; federally funded hospitals (military and Native); non-profit federally funded community health centers; and Native health corporations. Coordination of service delivery and systems development is an ongoing effort within the state among these entities.
/2003/ No change.
/2004/
The Health Care Delivery Environment.
In December of 2002, a new Governor was sworn in to begin a four year term of office. A change of administrations, especially when it involves a change in political parties as this one has, always brings changes - new commissioners and top level managers, new ideas and new philosophies. Alaska has experienced all of these including the appointment of a new Commissioner of Health and Social Services (DHSS). Senior management changes have also been made with the appointment of new Deputy Commissioners and Directors for most of the principal divisions within the DHSS. In addition to these administrative changes, on March 4, 2003, the Health and Social Services Commissioner announced a major reorganization of the DHSS. The reorganization includes internal consolidations that result in name and function changes for four divisions and the transfer of partner programs into the DHSS from other state departments. In part, the reorganization will restructure the way Alaska uses Medicaid funding for programs and maximize federal funding for state services.

The reorganization will result in significant changes for MCH programs. As of July 1, the Section of Maternal, Child and Family Health (MCFH), the agency that administers Title V funds, will be dissolved and specific programs and services within MCFH reassigned to new or existing Divisions within DHSS. Following is a list of the Divisions within DHSS that will have program responsibility for MCH programs formerly consolidated in the Section of MCFH.

Office of Children's Services (formerly Division of Family and Youth Services). In addition to child protective functions, the Office will include the following MCFH programs: Adolescent Health; Children's Initiatives/Special Projects; Healthy Families Alaska; Infant Learning/Early Intervention Program; WIC/Nutrition Programs; Community and Family Nutrition.

Division of Health Care Services (a blending of some MCH programs and the Division of Medical Assistance - DMA). In addition to Medicaid-related functions from DMA, the Division will include the following MCFH programs: Breast and Cervical Cancer Screening; Oral Health; EPSDT; Family Planning; Genetic Screening; Newborn Metabolic Screening; Newborn Hearing Screening; Specialty Clinics; Women's Comprehensive Health Care Initiative. The MCH Title V Block Grant will be administered by this division.

Division of Public Assistance. In addition to the current functions, the following programs will be transferred into the Division: Denali KidCare Outreach from MCFH; Child Care Block Grant Lead

Agency from the Department of Education. The current Denali KidCare outreach positions located in MCFH are eliminated from the budget, effective July 1, 2003.

Division of Behavioral Health (formerly Division of Mental Health and Developmental Disabilities). In addition to mental health programs from the former division, the following function currently under MCFH will be incorporated: Children's Behavioral Health. The Children's Behavioral Health Coordinator position currently located in MCFH is eliminated from the budget, effective July 1, 2003.

Division of Public Health. The MCH EPI Unit will move to the Section of Epidemiology and the Family Violence and Prevention Project will move to the Section of Community Health and Emergency Medical Services/Injury Prevention.

As part of the functional reorganization of DHSS, program staffing and budget adjustments and reductions are anticipated and will alter the way in which services are delivered or programs are supported. The reorganization is expected to present challenges as well as opportunities to address significant health issues faced by MCH populations in the state. Effects of the reorganization will be discussed in each of the sections of this grant application.

Principal characteristics important to understanding health needs of the state's population:
While Alaska is actively changing the way it administers programs and services for the MCH populations, significant health issues continue to demand our attention and thoughtful planning and delivery of health services.

Alaska is a large, sparsely populated state. According to 2000 Census data, the population of the state is 626,932. The land mass of the state encompasses 571,951 square miles, averaging a population density of just 1.1 persons per square mile; the lowest population density of any state. Approximately half (373,834) of the state's total population lives in three urban boroughs: the Anchorage Municipality, the Fairbanks North Start Borough and the Juneau City and Borough. The remaining population lives in frontier/remote areas of the state. (Defined as 0.5 to 9.9 persons per square mile for frontier areas and 0.4 persons or less per square mile for remote area designations.) Approximately 75% of Alaskan communities, where over half of the population lives -- including the state's capital city of Juneau -- are not connected by road systems and rely on air or boat travel to connect them to urban areas. Accessing "nearby health services" or specialized health care for these populations means travel by air or marine transportation systems. Some residents may travel distances equivalent to traveling from Washington, D.C. to New Orleans for even routine medical care. Specialty care, even in urban areas of the state is limited. For example, the only neonatal intensive care facility is located in Anchorage. Alaska faces significant challenges in assuring all MCH populations have access to acute medical and specialty care. For populations living in non-urban areas, a challenge also exits to provide routine preventive care such as well-child check-ups, prenatal exams and regular dental exams.

Another defining characteristic of the state's population are the racial groups and geographic distribution of those groups. The results from the 2000 Census data indicate that the majority of the population of Alaska is white only (69.3%). A significant proportion is Alaska Native/American Indian only or Alaska Native/American Indian in combination with another race (19%). Approximately 5% of the population is Asian and 4% African American. Hispanic/Latino ethnicity was reported by 4.1% of the population. Geographically, the racial distribution differs from the total population in many areas of the state, with whites the minority in a number of areas. For example, Alaska Natives/American Indians make up more than 75 % of the population in 8 of 14 remote areas of the state. Forty-six percent of Alaska Natives live in communities of less than 1,000 people. The largest minority population, Alaska Native, is much younger on average than the state as a whole (25.8 years). The largest differences in health status in the state are between Alaska Natives and the white population. Efforts of public and tribal health agencies have improved the health status of Alaska Natives over the years in many areas such as injuries and infectious disease, but some disparities persist. Health indicators show that Alaska Natives are at higher risk for a number of health issues. For example, key indicators show that Alaska Natives have higher rates of infant death and deaths among children (age

1 - 19 years), lower rates of prenatal care, higher rates of smoking during pregnancy, teen births and suicide mortality. These health risks combined with the fact that the majority of Alaska Natives live in frontier/remote areas where access to health care is limited, place Alaska Natives at even higher risk for poor health outcomes.

Alaska is a fairly young state, where the median age is 32.4 years. This compares to 35.3 years for the entire United States. Residents age 65 or older comprise only 5.7% of the population of Alaska compared to 12.4% for the U.S. population. Because the population is younger, fertility and birth rates are higher. Additionally, families living in non-urban areas tend to have larger families. The average family size (from 2000 Census data) in urban boroughs was 3.16 people. In frontier/remote areas combined it was 3.51 people. Alaska has the second highest fertility rate among the 50 states. The total fertility rate for Alaska (71.4 per 1,000) remains considerably higher than the national average (65.4 per 1,000). A significant decline in the overall teen birth rate has occurred (30 percent decline between 1990 and 1999 primarily attributed to the decline in births to females age 18 - 19); however data indicates that Alaska Natives have over twice the rate of teen birth as whites.

Finally, a characteristic that requires a significant investment of resources is the behavioral health issue that impacts MCH populations in the state. Alaska has the unfortunate distinction of having the highest suicide rate in the country. The suicide mortality rate is 100 percent higher in Alaska than the national rate. Mental health disorders, stressful life events and substance abuse are risk factors for suicide. Alaska also has the distinction of the highest alcohol consumption rate in the nation. Alaska has higher percentages of binge and chronic drinkers than the nation as a whole. Children are significantly impacted by alcohol and drug abuse, especially if their mothers are abusing. A majority of families in Alaska in the child protection system have problems with alcohol or drugs. The state has recognized and responded to significant behavioral health issues facing older populations and adolescents. Recently the state has also recognized that younger populations including infants and toddlers are also a population that can and does have behavioral health needs.

Current State Priorities and the MCH health role and responsibility

The Department of Health and Social Services has developed the following goals and strategies for FY04:
Goal #1: Establish fiscal stability to DHSS programs through federal fund maximization, prudent cost containment, and streamlined business processes. Reduce dependence on new state general funds through the following: replace $20 million in state dollars with federal Medicaid dollars in FY04 by implementing agreements between hospitals and state-funded community programs; offset $5 million in state dollars in FY04 with federal Medicaid dollars by investment in Alaska Native tribal health services infrastructure through cooperative agreements with the state, private health care providers, local communities and tribal programs; review business process and eliminate inefficiencies and redundancies; conduct program reviews of all DHSS programs to find options for offsetting state funds with federal funds; carry out aggressive federal agenda to lock in fair treatment of Alaska in funding formulas and policies across a diversity of federal programs; implement cost containment options to the extent feasible without disruption to essential services.

Goal #2: Expand access to cost effective quality services in underserved areas of Alaska through the following: carry out aggressive health and social services workforce development agenda in collaboration with the University, tribal health system, provider and employer organizations, and other stakeholder groups; develop integrated health services programs utilizing partnerships with the tribal health systems, the Denali Commission, the Alaska Mental Health Trust Authority, and other stakeholder groups; implement reimbursement for telehealth services; support the increased use of well-trained local residents in the delivery of a range of frontline prevention and treatment services under tribal health program auspice, for maximum federal fund benefit through Medicaid; develop juvenile substance abuse treatment capacity in rural Alaska.

Goal #3: Protect children and the public from negative effects of alcohol and substance abuse; reduce

impact of illness and injury and promote self sufficiency for all Alaskans through the following: establish Performance Improvement Plan (PIP) for child protection system (DFYS); maximize available resources to assure completion of the API replacement project; assure juvenile offenders are held accountable; open Kenai Youth Facility promptly; renovate Nome Youth Facility; and achieve expedited compliance with court directed treatment and tobacco enforcement policy; develop in-state capacity for provision of appropriate behavioral health services to children and youth, utilizing financing arrangements that assure best use of federal funds whenever feasible; maximize federal resources to support environmental health, disease control, injury prevention, and Homeland Security programs in Alaska; strengthen home and community based services programs and self-sufficiency programs to achieve improvements in quality and cost effectiveness.

All programs and services will be reviewed in context of the new Department goals. Based on these goals, the new Department organization, and the upcoming five-year needs assessment, the state's MCH priorities may change.

Current MCH programs have supported/will support the DHSS priorities as follows:
Participated in a critical review of programs to identify efficiencies and funding options;
Complete the "Rural to Remoteness: An Overview of Maternal, Child and Family Health in Region X States" initiative in collaboration with Idaho, Oregon and Washington, and continue to work with the MCFH Bureau to use this information to critically assess funding formulas for rural/remote/frontier areas in the states and to develop initiatives between state and federal government to reduce health disparities between urban and non-urban areas;
Continue collaboration with Native organizations to plan for and provide MCH services to Native populations;
Support local expertise in the provision of MCH services through the development of paraprofessionals to deliver WIC and Infant Learning Program services;
Supported state capacity to provide behavioral health services for children through the MCFH infant/toddler behavioral health grant;
Support community-based services through the continuation of grants to local organizations for MCFH services.

The Process to Determine Alaska's MCH Priorities:
A statewide needs assessment is completed every five years to guide the planning and delivery of health care services, and to establish MCH priorities for the state. The needs assessment is comprehensive, gathering information and data from MCH programs, partner programs and communities through a series of community based forums. During the interim years of the needs assessment cycle, an MCFH management team reviews the needs assessment to see if it is still valid, update relevant data, identify emerging issues from MCH populations and other factors which may affect the state's ability to address MCH health needs such as legislative mandates, state and national funding or personnel/ management changes. The management team, in consultation with programs and community partners may determine that a shift in focus or priorities is warranted. For example, MCFH has received increasing reports of concern from parents, child care providers, teachers and health care providers related to the behavioral health of young children. This trend is supported by national data demonstrating that 1 in 10 children have a mental health disorder that causes significant impairment in function. According to U.S. Census data gathered in 2000, Alaska has 47,591 children less than five years of age. The current system of services in the state for children between the ages of birth to five with potential mental health disorders is inadequate to address the needs of this population. In response, the MCFH identified children's behavioral health as an emerging issue and responded by establishing an Early Childhood Behavioral Health Coordinator position, sponsoring three annual training institutes in infant/toddler behavioral health. MCFH also applied for and received a federal U. S. Department of Health and Human Services 17 month planning grant. Proposed grant activities included conducting a needs assessment to understand the nature and extent of the capacity and barriers in Alaska's mental health system for young children, developing an action plan based on the findings of the needs assessment and raising public awareness of the importance of positive mental health in the early childhood years.

Disparities
Three years ago, MCFH facilitated a process for Region X states (Oregon, Washington, Idaho and Alaska) to look critically at health disparities between urban and non-urban populations. Using existing population and MCH health data, information about health care delivery systems and geographical characteristics, states were able to build a detailed picture of their MCH populations, their health status and barriers to accessing health services.

This research effort documents that significant disparities do exist in Alaska between urban and non-urban populations. Information on selected MCH health status indicators for Alaska show important differences in the prevalence, mortality, burden of disease and other adverse health conditions between urban and non-urban populations. For example, the average rates for those living in frontier and remote areas of Alaska were significantly higher in the majority of the indicators including childhood mortality, teen pregnancy, fertility, mothers reporting smoking and drinking. The rates also indicate that fewer women received early and adequate prenatal care.

Despite their poor health status, frontier and remote area MCH populations are less likely to access needed health care services. There are fewer health care facilities in non-urban areas. A low population means a smaller patient base to support health care facilities such as a hospital or clinic. In some remote Alaska communities, services are provided through a village health clinic staffed by a Community Health Aide. The lack of medical infrastructure in a small community and a limited patient base means that specialty services are rarely available or often nonexistent in frontier and remote areas. Recruiting and retaining physicians and primary health care providers for non-urban practices is also a barrier to providing health care services. Even if ideal health care systems were in place, socio/economic factors create additional barriers for populations living in frontier and remote areas. Compared to urban populations, frontier and remote populations are poorer, lack health insurance, have limited employment opportunities and face cultural or language barriers. Poverty is correlated with many of the health status and access disparities for non-urban populations. Higher unemployment, lower wage jobs and seasonal industries all contribute to the high poverty and near-poverty levels for non-urban populations. Uninsured populations are less likely to access routine, preventive care and more likely to seek care when health problems are severe and require treatment. Lack of preventive health care is a major contributor to poor health status for MCH populations.

The majority of residents in Alaska's frontier and remote areas are Alaska Natives. As previously noted, Alaska Natives are at higher risk for health problems compared to the general population. A culturally diverse workforce that reflects the culture, language and respects the traditions of the populations is a crucial strategy for reducing health disparities. While the state has made progress creating an infrastructure to train and recruit a culturally diverse workforce, many Alaska Natives do face cultural barriers when accessing health care. MCH supports local expertise and culturally competent care in the provision of MCH services through the training and development of paraprofessionals to deliver WIC and Infant Learning Program services.

Faced with the lack of appropriate health care in frontier, remote and even some urban areas of the state, residents are forced to travel to other communities for health care. Travel to access health care creates additional burdens for both the MCH populations, for the health care systems and the financial systems that support health care services. Families are forced to leave their homes and family support systems. For families with CSHCN, this can be particularly stressful. Families with children who require specialty care face hard choices when the services they need are not available in their community. They may have to choose between remaining in their community and traveling as often as needed for health care services; moving to an urban area where services are readily available and leaving their family and community support systems; remaining in their community and accessing itinerant care when it is available, or possibly getting no services at all. //2004//
/2005/No change in the goals or priorities of the department. //2005//

Increased Federal Support
Alaska has enjoyed increased federal support for a number of health and social service programs in the last year. A telemedicine program to link rural villages to health care facilities in large Alaska

cities, immunization programs, and an initiative for childhood injury reduction are but a few of the areas that have received new or additional federal funding in the last fiscal year. The infusion of dollars for health and social services has meant that needed health programs have been able to be established and where programs were already in place, expanded to meet burgeoning demand.
/2002/ In FY01, Alaska received additional federal funding for several MCFH programs including: $1.86 million for expanded home visitation services, $30.0 from a special federal appropriation for FAS Surveillance, $247.0 for Title X, family planning expansion, and $420.0 in TANF funds for pregnancy prevention.
/2003/ In FY02, Alaska received additional federal funding for the following programs: $190.0 for Population-Based Birth Defects Surveillance from CDC; $2.5 million (Better Beginnings II) in support of home visitation services (Healthy Families Alaska), $135.0 from CDC for Early Hearing Tracking, Research and Integration and $108.0 from MCHB for Women's Comprehensive Care Coordination.
/2004/ During FY2002, the Section applied for and received an oral health grant for $175,868 through CDC; a $50,000 planning grant from the Office of the Assistant Secretary for Planning and Evaluation for children's behavioral health; a $75,000 Using Loving Support grant from USDA for building a friendly breastfeeding community; and a $494,000 federal earmark administered through CDC for anemia research and treatment in the Yukon-Kuskokwim and Bristol Bay regions of the state. //2004//
/2005/ In FY03, the section of MCFH applied for and received a supplemental oral health grant in the amount of $39,000 to conduct a baseline open mouth screening survey of 3rd graders as part of data collection and assessment required to complete the oral health state plan; a $1.2 million (Better Beginnings III) earmark from Administration of Children, Youth and Families in support of intensive home visitation services (Healthy Families Alaska); a March of Dimes Leadership Grant in the amount of $15,000 for developing a folic acid community campaign that would be self sustaining as the March of Dimes moved into its next national campaign of "Prematurity Prevention"; and a total of $65,000 was received by the WIC program from USDA for training WIC center paraprofessionals in the breastfeeding "Using Loving Support" program. In addition, the study of anemia and the proposed treatment of H.Pylori as a treatment for anemia received an addition grant from HRSA as a federal earmark in the amount of $385,000 beginning August 1, 2003 as well as a non-cost extention of their previous grant award. //2005//

Alaska State Legislature
The Republican party has held the majority of seats in the Alaska State Legislature since the early 1990's. While numerous Republican candidates are up for re-election in November 2000, the balance of power is not expected to significantly change. While Alaska has had a Democratic Governor since 1994, the presence of a conservative Republican majority has had a financial impact on the entire Department of Health and Social Services in recent years. Of note is the FY98 move to eliminate the General Relief Medical Program which provided coverage for very low income persons with one of the following five conditions: Hypertension, Seizure Disorder, Diabetes Mellitus, Cancer requiring chemotherapy and Schizophrenia. Specific to MCFH has been the FY99 reduction in funding for the Healthy Families Alaska Program. Because increased federal support has allowed needed services and programs to be provided at little or no cost to the state, it is of concern to MCFH that the conservative majority will formulate an unrealistic view as to the actual cost of providing services and hold steady, or even reduce their portion of funding for services in the coming years.
On a more positive note is the possible introduction of "prescriptive equity" legislation in the next fiscal year. Scheduled to be introduced when the State Legislature convenes in January 2001, the measure would mandate insurance coverage for birth control for women in Alaska. Passage of such a law could increase access to birth control by reducing the financial barriers that many women face when managing their fertility. If introduced, MCFH will monitor with interest the movement of this legislation because of its positive impact on the health of women in Alaska.
/2002/ "Prescriptive equity" legislation was introduced in the 2001 legislative session but never got a hearing. In addition, there was a great deal of activity surrounding two bills, one related to Newborn Hearing Screening and one related to Breast and Cervical Cancer treatment. The Newborn Hearing Screening bill would have mandated newborn hearing screening for all infants in the state. The bill did not make it through the session because of issues related to costs of covering screening for uninsured infants. After much debate and controversy, the Breast and Cervical Cancer Treatment bill finally

passed, but with a sunset date in 2003. This bill provides Medicaid coverage for breast and cervical cancer treatment for women diagnosed through the federally funded Breast and Cervical Cancer Early Detection Program in Alaska which is operated by MCFH.
/2003/ During the FY02 legislative session, HB173, which mandated UNHS in 90% of Alaska's births by 2003, was re-introduced, but failed to pass due to the fiscal note attached to the implementation of this legislation. A bill intended to reduce the number of people eligible for the state's SCHIP program was introduced by the legislature but died due to public outcry. An abortion reporting bill passed, a prescriptive equity bill died, as did a bill to eliminate the sunset date of the Breast and Cervical Cancer Treatment bill and a bill to change parent consent from active to passive for school-based surveys. A bill to restrict Medicaid payment for abortions passed but was vetoed by the Governor.
/2004/ The sunset clause of the breast and cervical cancer treatment bill was eliminated, ensuring Medicaid coverage for breast and cervical cancer identified among women screened through the state's screening program, Breast and Cervical Health Check. //2004//
/2005/ Legislation mandating Newborn Hearing Screening did not move out of the Finance committee despite bipartisan support. The fiscal note was again revised to reflect the anticipated ongoing expenses of infants and children diagnosed as hard of hearing or deaf that would be served in early intervention for a longer time period as a result of earlier identification. During the State FY04 a number of bills were passed impacting the public's health. Although not yet signed by the Governor, they include the following outlined in four areas. In the area of Access to Health Care: HB 10 amends the definition of group health insurance, and allows the Department of Administration to obtain a policy or policies of group health care insurance for employers that are small businesses, nonprofit organizations, special services organizations, or small associations for insurance purposes; HB 260 extends the ability of licensed physicians and other health care providers to administer health care services free of charge. By exempting such services from malpractice liability, HB 260 would allow health care providers to donate their professional services at a lower personal cost. HB 260 will be especially helpful to retiring health professionals that wish to donate their services in rural communities but do not still carry medical malpractice insurance; SB 285 expands medical assistance coverage for targeted case management services. It also clarifies that school districts can seek reimbursement as Medicaid providers for services provided to students for rehabilitative services. In the area of Alcohol and other Drugs: HB 356 provides communities with the option to monitor the inflow of alcohol into their community through a locally operated distribution center. This bill extends the sunset date of alcoholic beverage site from July of 2004 to July 2008. This is particularly important in rural communities where the rate of alcoholism among teens and pregnant women is significant. Under House Bill 428 Civil Penalty: Underage Alcohol Purchases, an adult who orders or receives an alcoholic beverage, for the purpose of selling, giving, or serving it to a person under the age of 21 years, can be civilly liable to the licensee for a penalty of a $1,000. Likewise, the parent or legal guardian of a minor that solicits an adult to violate AS 04.16.060, can be civilly liable for a penalty of $1,000 to the licensee from which the alcoholic beverage was purchased, ordered, or received; SB 224 is a bill relating to lowering the legal level of intoxication for operating a motor vehicle, aircraft, or watercraft to .02 percent or the equivalent for persons under 21 years of age; relating to implied consent for purposes of determining consumption of alcohol; and providing for an effective date. It imposes a $500 fine and 20 to 40 hours of community service on minors for the first offense for operating a vehicle after consuming alcohol. On second offense, imposes $1,000 fine and 40 to 60 hours community service, third offense $1,500 and 60 to 80 hours community work service. In the area of Injury Prevention: House Bill 213 creates a three-tiered system whereby young drivers pursue their full, unrestricted driver's license with clarification of the definition of who may receive an exception for provisional license. This will hopefully assist in decreasing the number of teen motor vehicle fatalities; HB 351 adds carbon monoxide detection devices to the requirement in Alaska state statute (AS 18.70.095) that homeowners install and maintain smoke detectors and adds that landlords shall install the devices to be maintained by their tenants; HB 381 addresses loopholes in Alaska Statute regarding vehicular related child endangerment. This bill includes specific provisions to our existing child endangerment statutes pertaining to transporting a child in a motor vehicle while intoxicated or transporting a child in a motor vehicle and failing to use proper restraints; and HB 398

authorizes the State of Alaska and its municipalities to empanel teams to systematically review facts of escalating cases of domestic violence fatalities. This legislation would provide state and local governments with additional tools to gather information on many aspects of Domestic Violence with clarification on how the annual report is handled. In the area of Reproductive Health; SB 30 is an Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency. SB 30 directs the Department of Health and Social Services to produce a website with information and resources for women seeking adoption, abortion, childbirth, and contraceptive services. The information will be organized according to geographic region. SB 30 requires a physician or other health care provider performing an abortion to obtain voluntary and informed consent as defined in the bill. The bill has been a source of significant controversy.//2005//

State Hiring/Travel Freeze
By gubernatorial mandate, a state government hiring and travel freeze was implemented in 1999 that resulted in MCFH having 13 vacant positions for over 9 months. While the freeze has been lifted and the Section is now able to hire at will, a cap on out-of-state travel remains. Once the quota for Section out-of-state travel has been reached, staff who need to attend conferences or required program trainings must do so on their own. This cap presents an interesting challenge for many of the programs within MCFH and is expected to be in place indefinitely.
/2002/ There is no longer a hiring freeze and we are able to hire for vacant positions. There continues to be a cap on out-of-state travel.
/2003/ No change.
/2004/ No change. //2004//
/2005/ Position refills were closely scrutinized with additional justification required. Several positions were not allowed to be refilled. Travel was capped allowing for only one staff member to travel to a given conference or meeting even when a grant required more. //2005//

Denali KidCare (Children's Health Insurance Program)
Alaska's S-CHIP program, Denali KidCare, was implemented on March 1, 1999. Alaska chose to expand its Medicaid program to maximize services rather than create another administrative structure with the additional federal funding. During the first year of operation, the program's main efforts centered on outreach and enrollment of children. By the end of the first federal fiscal year (7 months from the programs inception), the Medicaid program as a whole saw an increase of 7,130 children enrolled (58,266 in FFY98 to 65,396 in FFY99). S-CHIP enrollment (Title XXI) was 8,033. By the end of its first full year of operation, the program had exceeded its three-year enrollment goal of 11,600 children.

While it is difficult to precisely determine the increased Title XIX enrollment as the result of the increased outreach efforts, the Department of Health and Social Services is certain this occurred. As with many other states, there have been decreasing numbers of children enrolled in Medicaid in conjunction with implementation of welfare reform efforts. In Alaska the number of children enrolled in Title XIX did not reflect a dramatic decrease however, and dropped only 1.6% from 58,266 in FFY98 to 57,363 in FFY99.

Following the success of its outreach and enrollment efforts, the program has shifted its focus to improve access to care. While children are able to access acute medical need services in a timely manner, there is some delay in access to well child exams and other preventive services, especially those related to dental health. Efforts to increase private dental participation in Medicaid/Denali KidCare have been among the programs highest priorities. The Division of Medical Assistance has been meeting regularly with the state dental association to develop strategies and recommend changes to the current administrative process that serve as barriers to provider participation in the program. At this time it is difficult to evaluate any increased access to dental services as a result of the work currently underway.
/2002/ 13,143 children were enrolled in Denali KidCare in June 2000. The Children's Defense Fund in its report "All Over the Map" ranked Alaska number one in the nation for the rate at which the state

was enrolling S-CHIP and Medicaid children.
/2003/ The monthly average number of enrolled Title XXI eligible children during the past year was 12,000; in April 2002, 13,200 were enrolled. The monthly average number of pregnant women enrolled during the last year was 2,900; in April 2002, 3,300 were enrolled.
/2004/ The monthly average number of enrolled Title XXI eligible children during the past year was 12,195; in April 2003, 12,089 were enrolled. The monthly average number of pregnant women enrolled during the last year was 3069.//2004//
/2005/ The monthly average number of enrolled Title XXI eligible children during the past federal fiscal year was 11,308; in April of 2004, 12,159 children 0-21 were enrolled. The monthly average number of pregnant women enrolled during the last fiscal year was 561. The numbers previously reported were not accurate as they represented a total number of women enrolled as a total moving average as opposed to a per month number enrolled.//2005//

B. AGENCY CAPACITY

The overall program capacity of MCFH has increased over the past year and is expected to continue. The redesign of MCFH databases to make them relational and allow for greater transference and sharing of information; the building of new systems to better track program indicators; the integration of programs into the Section (i.e., the Breast & Cervical Health Check Program) and the hire of a Pediatric Epidemiologist are all measures which have positively impacted program capacity. In the upcoming year, further integration of programs (i.e., the Teen Pregnancy and Parenting Program, currently housed in Juneau, Alaska) and increased federal support for specific MCFH efforts (i.e., the FAS Program) will allow for continued capacity building through more seamless delivery of services and greater collection, management and warehousing of data.

/2002/ In 2001, MCFH increased its capacity in many Units: the FAS Surveillance Project in the MCH Epidemiology Unit added two medical records abstractors and a statistical clerk; a new medical records abstractor position was also established in the EPI Unit in support of the birth defects registry; a program coordinator position was established and filled for children's behavioral health; a program manager for newborn metabolic screening and a teen pregnancy prevention specialist position were also established and filled. The Section underwent some reorganization to establish a Data Management Unit within the Administrative Unit which houses all of the analyst/ programmer positions supporting Section programs such as WIC, Healthy Families and Early Intervention. And finally, the Section established a Child Health Unit which will house the Healthy Families Program, Dental Health initiatives, and other child health programs. The Epidemiology and Evaluation Unit was re-named the MCH Epidemiology Unit.

/2003/ The Section grew dramatically in August 2001. The source of growth was the re-organization of the state Medicaid Services Unit. Twelve positions from this unit, formerly housed in the Public Health Director's Office, were incorporated into the Section. The Children's Health Unit, established in July 2001, incorporated most of the positions including six professional positions focused on statewide outreach for Denali KidCare (Alaska's child health insurance program), two professional positions which support the State's EPSDT program, a clerical position to support EPSDT and one position supporting the oral health program. Two data positions were incorporated into the Section's Data Management Unit. Three of the twelve transferred positions are located in Juneau, one in Fairbanks, and eight in Anchorage. The Section also incorporated an additional health program manager position as a result of other reorganization in the Public Health Director's office. The position, which focuses on special projects, is located in Juneau but is part of the Children's Health Unit based in Anchorage. A new position established in the Section in FY02 was a Public Health Specialist position in the Women's and Adolescent Health Unit to provide technical assistance to providers for Family Planning and the Women's Comprehensive Care Initiative.
Coordination between and integration of the Anchorage and Juneau offices takes place in many forms including: weekly Unit Manager meetings; individual unit staff meetings; distribution of unit and Section weekly reports; regular travel by the Section Chief, Data Management and Children's Health Unit Managers to Juneau; integrated monthly All Staff meetings; unrestricted e-mail and phone use; a monthly Section newsletter distributed to staff; and team building activities.

/2004/ Alaska's state health agency, the DHSS has developed significant capacity to serve women and children from prenatal care and birth through adolescence and adulthood; and including health care services for CSHCN. This capacity has been built on the foundation of strong partnerships and collaboration among federal programs, the state, Native health care systems community-based organizations.

Capacity building begins with recognizing critical issues the state faces in providing comprehensive care. For example as a result of the geographic isolation and low population density, providers in Alaska have determined the concept of "medical home" for Alaskans requires a broad definition. In many frontier areas, medical services are limited to a small clinic staffed by a Community Health Aide with basic training in primary, preventive and emergency medical care. Itinerant public health nurses visit most of Alaska's rural communities providing the "medical home" for many of Alaska's children and families. An R.N., Nurse Practitioner, Community Health Aide or Physician's Assistant provides primary and preventive care in many cases. Due to chronic staff shortages, unpredictable weather, and high cost of travel, villages and communities may receive a visit from an itinerant Public Health Nurse as frequently as monthly or as infrequently as bi-annually. The inability to access specialty care poses significant hardships for CSHCN. A coalition of state and private agencies arrived at a definition of "medical home" for Alaska CSHCN: The medical home is where a child with special health care needs and his or her family can count on having medical care coordinated by a health care professional they trust. It is not a building, house or hospital, but rather an approach to providing quality and coordinated services. Primary health care providers and families work as partners to identify and access all of the medical and non-medical services needed to help CSHCN achieve their potential. Working from this base, a coalition of providers are currently engaged in building a base of specialists and sub-specialists in children's health, holding specialty clinics in rural communities, coordinating specialty care with families either on an iterant basis or helping families access services in larger communities.

Community-based services are integral to a comprehensive system of care in Alaska. The state offers grants to local health care providers and organizations to deliver direct services to women and children. These grants build health care capacity at a local level by supporting local expertise and health care facilities as well as supporting the economic base of small communities with jobs and career options for local populations. Direct grants to local communities are available for Infant Learning Programs, WIC, Healthy Families, school-related initiatives, family and community nutrition, breast and cervical cancer screening outreach and oral health. These locally based efforts are also important to bring culturally competent care to predominately Native communities found in remote and frontier areas of the state. For example, the state supports training and education programs, some through the University of Alaska distance delivery or on-campus programs, to educate and train paraprofessionals to deliver WIC, Infant Learning, community health aides, and professional services such as nursing, early childhood teachers and others.

The health of newborns and young children is another capacity building effort important for the state health agency. Outreach efforts through the SCHIP program, Denali KidCare, have been instrumental in enrolling pregnant women in the health insurance program so they can access needed services. The EPSDT program promotes important prenatal care and provides outreach so newborns can be enrolled in Denali KidCare soon after birth. Health information is provided on a regular basis to Medicaid/Denali KidCare recipients on well-child exams, health and safety and how to access medical care through Medicaid enrolled providers. All of these efforts require partnerships between the various state agencies administering the programs, local providers and local program administrators. The Section of MCFH administers a comprehensive program for newborn metabolic and hearing screening. Metabolic screening is required by state law and all newborns are screened with follow-up health care services and long term medical care coordination offered for all newborns diagnosed with a metabolic disorder. The state has also introduced legislation to require all newborns receive hearing screening and is building the capacity in partnership with hospitals and private providers to ensure all newborns are screened and follow-up diagnostics and treatment is available for all children who do not pass the initial screens. This newborn screening initiative has been an important and successful

partnership between the state, local hospitals, specialty providers and advocacy organizations to provide a comprehensive system of care for children with hearing impairments.

One of the states most active community-based health care systems is the Alaska Public Health Centers. The state currently supports Public Health Centers in 23 communities and offers itinerant services to remote/frontier communities that do not have a health center. The Public Health Centers are staffed by Public Health Nurses and the Division of Public Health, Section of Nursing oversees staffing of the centers. The Section of MCFH and Nursing have long been partners in identifying and providing needed services for the MCH population. For example, family planning services are offered at Public Health Centers and contraceptives purchased with MCH block grant funds support that effort. Public Health Centers and Public Health Nurses are also the state's frontline providers of prenatal care, immunizations, referrals for specialty care, EPSDT services, maternal health services, etc.

Over the next year, Alaska will be addressing significant funding issues that may affect the state's capacity to provide services to women and children. Currently the state is evaluating the effect of budget reductions on several MCFH programs. However, at this time budget reductions are unknown. //2004//

/2005/ The reorganization of the Department of Health and Social services and the resulting changes for what had been the Section of Maternal, Child and Family Health have provided many challenges and opportunities for the staff who provide services and manage and/or oversee programs for pregnant women, teens, children and their families. Programs have experienced a decrease in their capacity to maintain their programmatic databases. Programming support has been negotiated for part of this fiscal year, but with the reorganization of all information technology staff into a centralized department, future support is uncertain.

New systems of communication between reorganized and new divisions and their programs are beginning to take shape. Assisting the divisions to think about the needs of the MCH population has required more overt efforts than in the past. These ongoing efforts will be critical as MCH staff move into the work of the five year needs assessment.

The reorganization has provided the opportunity to strengthen new and existing partnerships. As an example, work on the Prematurity prevention campaign with the March of Dimes has helped to forge new relationships with the University of Alaska Anchorage, the business community, and new providers.

Although MCH programs specifically will not experience funding cuts in the coming state fiscal year, the states public health nursing centers will be experiencing significant budgetary challenges in the next state fiscal year which will impact their delivery of core public health services. How these changes might affect the services delivered in collaboration with our division has yet to be determined as the budget has not yet been signed. The use of Block grant funds to assist as a gap filling measure has been proposed //2005//.

C. ORGANIZATIONAL STRUCTURE

Organizational charts for the State Health Department, Division of Public Health and Section of MCFH can be found under Other Supporting Documents. The MCFH Organizational Chart includes positions by program, as well as job classification.

/2004/
Alaska's state health agency, the DHSS is one of 15 Departments comprising the Executive Branch of Alaska's state government. The Governor directs the activities of each of these departments through an appointed cabinet level commissioner. The DHSS organizational structure is broken down into

Divisions with an appointed director to oversee all activities for their Division. The Division of Public Health within the DHSS has been charged with primary responsibility for MCH programs. An organizational chart for the overall reorganization of the Department of Health and Social Services is attached.

As of July 1, 2003, a major reorganization of the DHSS will change the administration of Title V funds and MCH programs. The DHSS will continue to act as the state health agency. Oversight of Title V funds will shift from the Division of Public Health to a new Division, the Division of Health Care Services. The Title V Director will be transferred to and housed within the Division of Health Care Services as the former director is being transferred to the Office of Children's Services. As previously noted in the narrative, specific MCH programs previously consolidated within the Section of MCFH/Division of Public health will be dispersed to new or existing Divisions.

Organization charts for the DHSS and each of the Divisions housing MCH programs are currently being developed and reviewed. It is anticipated that official organization charts for FY04 will not be available for including in the grant application; however, they may be available at the time this grant application is reviewed. New directors have been appointed to each of the Divisions that will administer dispersed MCH program elements, with the most recent appointment for the Office of Children's Services. The start date for that Director will be September 1, 2003. Each of these Directors will be responsible for building the organizational structure for their Division and it is anticipated that adjustments will be made to the draft organization charts as the directors restructure the Divisions.

Alaska differs from most states in that it does not have county health departments that function under the administrative arm of the state health agency. Alaska's health care system rather is a mix of direct state, tribal or federal, local health care agencies and private practice health care providers. The state operates local public health centers in 23 communities and offers itinerant public health nursing services for those communities not served by public health centers. Two urban communities have locally organized health departments, the Municipality of Anchorage and the North Slope Borough. Federally funded hospitals provide health care services to Alaska's military and Native populations. Additionally, health care services are provided to Alaska Natives through health clinics operated by the Indian Health Service or Alaska Native Health Corporations. Other services for MCH populations are provided by non-profit agencies using grant funds from state, federal or other non-governmental funding sources. The state, then, can be involved in providing health care services on numerous levels, as a direct service provider, through grants, or as a partner with Native, federal and private health care organizations in the planning, provision and coordination of health care services.

For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:

1. Infant Learning Program: This program has been under the Section of Maternal, Child and Family Health; it is moving to the Office of Children's Services on July 1, 2003. The state general funds spent on this porgram provide the bulk of the state match for the Block Grant and much of the state portion of the federal-state partnership. While the Department of Health and Social Services is the umbrella organization to both the Title V administrative organization (i.e., Division of Health Care Services) and to the Office of Children's Services, there will be more coordination effort required in the future to provide information required for the Block Grant application. For example, it will be more complicated to track ILP expenditures in support of the MCH-related populations and initiatives. We are not sure at this time how we will work out reporting for the Block Grant application requirement of expenditures by level of the pyramid and by population group.
2. All other MCH-related initiatives not moving to Health Care Services on July 1, 2003: These programs and functions include data management and evaluation, maternal and child health surveillance, child health indicator tracking, adolescent health, family violence prevention, and some administrative functions. MCFH has been, but will no longer be, responsible for a large portion of work previously associated with the federal-state partnership after July 1, 2003. State general funds have been used by the Section to support a variety of initiatives and personnel costs for work done relevant

to Title V and which were considered in our Title V grant application. While we anticipate most of the work to continue and that collaborative efforts will occur, it will be very difficult to track the state funding being spent in Divisions outside of Health Care Services and to track how the expenditures support MCH populations and levels of the pyramid. MCH Block Grant funds will continue to be used across Divisons to support many important functions and initiatives for our target populations. //2004//

/2005/
As of July 1, 2003, a major reorganization of DHSS changed the administration of Title V funds and the MCH programs. DHSS has continued to act as the state health agency. Oversight of the Title V funds shifted from the Division of Public Health to the Division of Health Care Services. Since that time, a new Title V/CSHCN director has been named as the former Title V director became the Deputy Director of Health Care Services. As outlined in the section "Other MCH Capacity", MCH programs have been dispersed to new or existing divisions. Brief biographical sketches of the Title V/CSHCN director and other senior level management employees are attached.

For those programs funded by the Federal-State Block Grant Partnership budget, the state's administrative role is as follows:
1. Early Intervention/Infant Learning program: The program now resides in the Office of Children's Services. The state general funds spent on this program provide the bulk of the state match of the Block Grant and much of the state portion of the federal-state partnership. While DHSS is the umbrella organization for both the Title V administrative organization (i.e. Division of Health Care Services) and the Office of Children's Services, there will need to be a coordinated effort to provide information required for the Block Grant application both programmatically as well as fiscally.
2. Other MCH related initiatives that did not move to the Division of Health Care Services included data management and evaluation, maternal and child health surveillance, child health indicator tracking, adolescent health, family violence prevention, WIC and Family Nutrition, Healthy Families Home visitation program, and some administrative functions.

As stated previously, this last year has been a year of transitions. With the changes that ensued as a result of the reorganization, there has been a significant change in the sphere of Title V administrative and programmatic oversight by the Title V director. Much of the work previously done by the section of MCFH is now conducted in other divisions managed by separate directors with differing agendas and priorities. In addition, a significant amount of turnover in personnel has occurred affecting the historical knowledge that once existed. Further turnover is expected in this next fiscal year. //2005//

D. OTHER MCH CAPACITY

The Section of Maternal Child Family Health employs seventy six (76) staff members and has thirteen (13) vacancies; 28 clerical and administrative staff support the work of 48 technical and program specialists. Three staff members have PhDs, one is an MD, and 75% of the technical/program specialists have master's degrees. The senior level program management employees (Section Unit Managers) all have master's degrees.
/2002/ The Section of MCFH now has 96 positions with 18 currently vacant. Of the vacant positions, several are newly established. The Section of MCFH staff is divided between Anchorage and Juneau locations. The Juneau location houses15 staff members associated with the WIC program and one staff person in the Women's and Adolescent Health Unit. In FY01 the Section hired an employee who is the parent of a child with special needs; she is the Children's Behavioral Health Coordinator and is a permanent, full-time state employee.
/2003/ The Section increased in size to 105 permanent positions and seven non-permanent positions; approximately 13 are vacant. Three staff members have a PhD or DrPH degree, one is an MD, one is

a DDS, and over half of the technical or program specialists have master's degrees. The decline in master's prepared staff is attributed to an increase in paraprofessional, entry-level professional staff and support staff positions as well as difficulty in recruiting staff with higher education and extensive experience.
Brief biographies of senior level management staff are included in Other Supporting Documents.
Programmatically, families participated in the development of individual family service plans (IFSP) and served on program advisory committees for individual EI/ILP grantees. Families were involved in policy activities in the State CSHCN program by serving as members on the Interagency Coordinating Council (ICC) and by advising CSHCN staff on various issues and participating in the MCH Advisory Committee.
/2004/ Prior to the reorganization of DHSS, the Section of MCFH within the Division of Public Health had approximately 110 permanent employees and seven non-permanent positions. Throughout the course of the program year, some of these positions were vacant as recruitment and hiring could take several months depending on the level of expertise required by the position.

The reorganization of DHSS, in addition to shifting positions and functions to other Divisions, included eliminating 14 positions resulting in layoff of several employees as of July 1, 2003. The current MCH capacity will be reduced by approximately 12% in FY04. These reductions include:

Denali KidCare (Children's Health Insurance Program) Outreach. All six positions responsible for outreach activities throughout the state will be eliminated. Outreach responsibilities will be incorporated into the work of current personnel in the Division of Public Assistance. This change will likely result in decreased capacity to enroll eligible children and pregnant women in the Alaska's SCHIP program, Denali KidCare.

Children's Behavioral Health. In FY02, MCFH hired a program coordinator to address the behavioral health needs for children. This employee also brought the perspective of a parent of a special needs child to the organization. This position was eliminated in FY04 and the program functions, including the recently awarded federal planning grant for early childhood behavioral health, will be transferred to the Division of Behavioral Health. It is anticipated that an existing position in the Division will absorb these program activities.

Maternal/Infant Mortality Review. A position responsible for coordination and review of maternal/infant mortality data was eliminated. The future of this activity is unknown.

Administrative support. Four administrative clerk positions and one accounting clerk position were eliminated. These positions supported various MCH programs.

Women's and Children's Health Specialist. This position has been vacant awaiting reclassification and was eliminated.

In addition to the loss of 14 fulltime positions, turnover of staff is anticipated. While turnover does occur in any organization, the reorganization is likely to bring a higher than usual rate of turnover as employees positions are shifted and program responsibilities change.

It is not possible to predict changes in the level of support or program capacity that MCH programs will have as the reorganization is implemented. However, assurances have been given by the DHSS Commissioner and new Division Directors that MCH programs will continue as they have with the same level of commitment from management, and with the expectation that the same high level of services will be available to Alaska MCH populations.

As of July 1, the following MCFH state staff has been assigned, under the reorganization, to the following Divisions.

Office of Children's Services (38 positions)
Adolescent Health - 1 position

Community & Family Nutrition - 1 position
WIC/Nutrition Programs including analyst/programmer support - 20 positions
Children's Initiatives/Special Projects - 2 positions
Infant Learning Program including analyst/programmer support - 4 positions
Healthy Families Alaska - 2 positions
Grants/contracts administrator - 1 position
Nutrition and ILP Unit Managers - 2 positions
General administrative support positions - 3 positions
Public Health Specialist - vacant - 1 position

Division of Public Health, Section of Community Health and Emergency Medical Services
Alaska Family Violence Project - 2 positions
Child Injury Prevention - 1 position

Division of Public Health, Section of Epidemiology (22 positions)
Epidemiology and Evaluation - 11 positions
PRAMS - 2 positions
FAS Surveillance - 3 positions
Birth Defects Registry - 3 positions
Child Health Indicators Project - 2 positions
Maternal Mortality/Child Fatality - 1 position
Administrative Support - 7 positions
MCH EPI Unit Manager - 1 position
Medical Epidemiologist - 1 position
Programmatic Analyst/Programmer IV - 2 positions

Division of Health Care Services (34 positions)
Breast and Cervical Cancer Screening including analyst/programmer support - 8 positions
EPSDT - 3 positions
Family Planning - 1 position
Genetics Program - 1 position
Newborn Metabolic Screening - 2 positions
Newborn Hearing Screening - 1 position
Oral Health - 2 positions (1 in Juneau; 1 in Anchorage)
Specialty Clinics - 1 position
Women's Comprehensive Care - 1 position
Administrative Support - 10 positions
Section Chief and Unit Managers - 4 positions

With the implementation of the Department reorganization on July 1, 2003, there will be only one staff person (the state Dental Director and manager of the oral health program) from the new MCH lead organization -- the Division of Health Care Services -- who will be located in Juneau. All other MCH staff going to this new Division will be located in Anchorage. The Oral Health Program manager will participate in management and staff meetings (telephonically and face-to-face) and will be in contact with Anchorage-based staff through telephonic and electronic communications.

Brief biographical sketches of the Title V Director, CSHCN Director and other senior level management employees moving to the new Health Care Services Division are attached.
//2004//

/2005/ As of July 1, 2003, the major reorganization of DHSS changed the administration of Title V funds and of the MCH programs. DHSS has continued to act as the state health agency. Oversight of the Title V funds shifted from the Division of Public Health to the Division of Health Care Services. Since that time, a new Title V/CSHCN Director has been named as the former Title V Director became the Deputy Director of Health Care Services. Traditional maternal-child programs are now distributed in four divisions. Each of the divisions

experienced turnover this state fiscal year and many positions remain vacant or will experience a change in their position description.

Office of Children's Services (34 positions-with 20 positions to move to July 1, 2004)
Adolescent Health - 1 position-vacant-position duties to be changing
Community & Family Nutrition - 1 position-vacant
WIC/Nutrition Programs including analyst/programmer support - 20 positions-all are transitioning from WIC to a centralized IT division
Children's Initiatives/Special Projects - 1 position-changed of duties to focus on transition of 18 year olds from state custody to adult status
Infant Learning Program including analyst/programmer support - 4 positions
Healthy Families Alaska - 2 positions
Grants/contracts administrator - eliminated
Nutrition and ILP Unit Managers - 2 positions
General administrative support positions - 2 positions
Public Health Specialist - 1 position - vacant

Division of Public Health, Section of Community Health and Emergency Medical Services
Alaska Family Violence Project - 2 positions
Child Injury Prevention - 1 position

Division of Public Health, Section of Epidemiology (20 positions with two to move July 1, 2004)
Administrative Support-4 positions
Epidemiology and Evaluation - 14 positions- total
PRAMS - 2 positions
FAS Surveillance - 3 positions
Birth Defects Registry - 3 positions
Child Health Indicators Project - 1 position
Maternal Mortality/Child Fatality - 1 position - vacant
Administrative Support - 1 position
MCH indicators surveillance project - 1 position- soon to be vacant
MCH EPI Unit Manager - 1 position
Medical Epidemiologist - 1 position
Programmatic Analyst/Programmer IV - 2 positions- moved to centralized IT division

Division of Health Care Services (30 positions with four to move to a centralized division July 1, 2004))
Breast and Cervical Cancer Screening including analyst/programmer support - 8 positions. Three positions will move to the centralized IT
EPSDT - 2 positions
Family Planning - 1 position
Genetics Program - 1 position
Newborn Metabolic Screening - 1.5 positions
Newborn Hearing Screening - 1.5 positions
Oral Health - 2 positions (1 in Juneau; 1 in Anchorage)
Specialty Clinics - 1 position
Women's Comprehensive Care - 1 position
Administrative Support - 8 positions
Deputy Director - position
Unit Managers - 2 positions. One of which is the Title V / CSHCN director

MCH capacity is located in the Division of Health Care Services, however with a continued decrease in positions, the capacity to respond to new MCH initiatives has been and will continue be effected. Specific effects of these reductions are difficult to predict. However, assurances have been given by the DHSS Commissioner and new Division Directors that MCH programs will continue as they have with the same level of commitment from management,

and with the expectation that the same high level of services will be available to Alaska MCH populations. //2005//

E. STATE AGENCY COORDINATION

No Changes or Updates.
/2002/ The Section of Maternal, Child and Family Health is well-known for its collaborative approach to systems development, implementation and service delivery. The Section has numerous relationships with a variety of agencies and groups in order to achieve its mission. Some of our partners with whom we have collaborative working relationships and examples of the related initiatives include:
1. other Sections within the Division of Public Health such as Nursing, Community Health and Emergency Medical Services, Vital Statistics, Medicaid Services (women's health; injury prevention and chronic disease prevention; adding newborn metabolic and hearing screening data to electronic birth certificates; S-CHIP)
2. other Divisions within the Department of Health and Social Services such as Juvenile Justice (Adolescent Health Advisory Committee); Mental Health and Developmental Disabilities (Early Intervention; children's behavioral health)
3. the Department of Education and Early Development (Asset building for adolescent health; Building Blocks Initiative to improve the health and well-being of young children, prenatal through age 8; training)
4. other state agencies such as the Mental Health Trust Authority and the Governor's Council on Developmental Disabilities and Special Education (funding and systems issues for CSHCN)
5. private physicians and health care providers, local health departments, private non-profits, private and federally funded hospitals (All Alaska Pediatric Partnership; delivery of breast and cervical cancer screening and diagnostic services; family planning services; specialty clinics; FAS surveillance; early hearing detection; newborn metabolic screening; WIC)
6. our community-based grantees (non-profits, local and Native health agencies) who deliver services such as Early Intervention, WIC, Healthy Families, Breast and Cervical Cancer Screening Outreach (training, policy development and implementation; data systems)
7. health-related organizations such as the March of Dimes, the YWCA and American Cancer Society (folic acid campaign; breast and cervical cancer screening; cardiovascular health) and Stone Soup Group (CSHCN issues)

/2004/ One of the challenges of the reorganization of DHSS is to develop a process and/or mechanism for collaboration at all levels. Certainly the spirit of collaboration supports the goals of the department's reorganization to promote program efficiencies, reduce duplication of effort and provide customer satisfaction. As the DHSS begins the process of reorganization, program staff will continue to maintain relationships and help to establish a process for continued collaboration. However, it is unknown at this time the level of collaboration that will be established. In addition, as current MCH program staff transition and turnover under new divisions, the history and perspective of past relationships will be lost and difficult to re-establish. Following is a description of the current level of coordination and collaboration between the MCFH and their partners that will serve as a standard in the future.

The Section of MCFH has had a rich and respected history of collaboration with partner programs within state government, at the federal level, and within Alaskan communities. The Section is grounded in the philosophy that strong partnerships and a collaborative approach are critical for systems development, implementation, service delivery and ultimately achieving the mission of the Section.

Essential MCH programs have in the past been co-located within the MCFH Section, including: WIC, CSHCN programs, EPSDT, SCHIP outreach staff (Denali KidCare), family planning, maternal health, adolescent health, oral health, child/family abuse and neglect prevention programs. The Section has

also built a necessary and highly valued data support structure. Functioning as a team, these programs have been able to develop and support a statewide, comprehensive array of services for MCH populations. As a Section within the Division of Public Health, MCFH has had daily contact and close working relationships with Public Health Nursing, Epidemiology, Community Health & Emergency Medical Services (CHEMS) and Vital Statistics. Each of these sections have supported MCH through data collection and analysis, providing direct health care services, extending prevention and treatment services for MCH populations.

Close working relationships have also been maintained with other Divisions within the DHSS. These include:
Division of Juvenile Justice through the Adolescent Health Advisory Committee

Division of Mental Health and Developmental Disabilities through early intervention programs and the children's behavioral health initiative

Division of Family and Youth Services through several initiatives including Children of Incarcerated Parents, foster parent health care support, Health Passport initiative for children in state custody

Division of Alcohol and Drug Abuse through Adolescent Health Program and Youth Developmental Assets

MCFH has also played a lead role in bringing together partners from other state departments and actively participating in program activities generated by those departments. These include:

The Department of Education and Early Development provides direct funding and program administration for Head Start, preschools, child care and public schools. These programs provide an opportunity to increase immunization rates, enroll eligible children in SCHIP/Medicaid, provide important health information, promote well child checkups and provide behavioral health services and services for CSHCN. The public school systems are also an essential vehicle to promote the health of adolescents. Staff from MCFH actively participates in program planning and service delivery for these programs. In addition to these on-going activities, collaboration between the nutrition programs in MCFH and Department of Education was initiated this year with the application and receipt of a Team Nutrition grant and obesity grant. Two years ago the Interdepartmental Council on Early Childhood was established through a Memorandum of Understanding between the DHSS and DOE. A co-chair is appointed from each department and the Council has met quarterly with the goals of jointly developing initiatives and activities that bridge the gap between the departments and promote comprehensive service delivery and planning for children and families.

The Department of Public Safety has program responsibility for the Council on Domestic Violence and Sexual Assault. The Council supports a system of shelters for women and children as well as initiatives and grants for community based prevention and intervention. A strong partnership has existed between the Council and the MCFH Family Violence Prevention Project.

The Department of Corrections has partnered with the DHSS and private non-profit service agencies to provide services to children of incarcerated parents. This unique partnership has resulted in identifying children and resources to promote their health, custody planning, and supports through the school system.

A strong collaboration between the Section of MCFH and health care providers and agencies has been a priority. Staff from the Section of MCFH are active members of the All Alaska Pediatric Partnership and maintain through this organization contact with health care practitioners, hospitals, clinics and other health care organizations. The Newborn Metabolic and Newborn Hearing Screening programs have also developed strong working relationships with primary care facilities and practitioners throughout the state. Breast and Cervical Health Check, family planning and specialty clinics also promote strong links to community-based service providers.

At the community level, grantees deliver direct services for WIC, Early Intervention, Breast and Cervical Cancer Screening Outreach. MCFH staff have supported community efforts to promote and plan for the health of children and families. MCFH has also provided direct help when significant health problems have occurred in communities with limited resources. There will continue to be a commitment to service coordination efforts and to addressing new challenges of coordination in the future in light of the reorganization of MCH-related programs and initiatives. //2004//

/2005/ As a result of the reorganization of DHSS and the resulting changes for the Section of Maternal Child and Family Health, patterns of work and relationships with other divisions within DHSS changed considerably. In preparation for the actual move of personnel and programs to other divisions or sections, many meetings were held with the new division's staff assigned to manage the transferring MCH programs. This was initiated to assist in orienting them to the program, the populations served, the flow of revenue and expenses, the type of cost accounting required (particularly for block grant reporting), the type of work done, grant funding (if applicable), data needs, and so on. This work consumed the majority of the fiscal year and into the current federal fiscal year. Therefore, because energies were focused on transitioning programs and maintaining services, less energy was directed at developing new relationships. To follow is a run down of the status of relationships that had been reported on in 2004:

1. Division of Juvenile Justice: The Adolescent Health position was eliminated and thus the Adolescent Health Advisory Committee was eliminated as well.

2. Division of Senior and Disability Services (formerly the Division of Mental Health and Developmental Disabilities): This division was significantly reorganized with mental health services combining with the Division of Alcohol and Drug Abuse to form a new Division of Behavioral Health. Our work previously had focused on infant and child behavioral health. The federal grant received for planning and infrastructure building was transferred to the Division of Behavioral Health. The Title V / CSHCN director has recently contacted the program manager of this grant to offer assistance in moving forward in fulfilling the grant's objectives. Division of Health Care Services staff recently began to work closely with staff that manage the disability waivers and children with complex medical condition waivers to streamline the process of discharges from the newborn and pediatric intensive care units and facilitate community services. In addition, former MCH staff are currently assisting in the regulation process for special medical equipment.

3. Division of Family and Youth Services. This division was renamed the Office of Children's Services (OCS) and is managed by a Deputy Commissioner. The previous initiatives of Children of Incarcerated Parents, the Health Passport Initiative and foster care health care support are not active initiatives at this time. The Title V / CSHCN director and former MCH staff work with the two programs transferred to OCS; WIC and the Early Intervention/Infant Learning program. They have focused their efforts in the area of early hearing detection and intervention, the Early Comprehensive Care and System grant, and recently renewing the 5-A-Day nutrition program.

4. Division of Alcohol and Drug Abuse. This division combined with mental health to form a new Division of Behavioral Health. Within this division is the Prevention and Intervention Unit where a new position focused on Resiliency and Youth Development resides. We are looking for opportunities to collaborate as this position and its staff member get established.

5. Work with other departments: The work formerly done in collaboration with other departments has not proceeded and in some cases has ceased as a result in the changes in goals with the new directors and commissioners. As the new administration has now begun to establish itself, the Title V / CSHCN Director and other Division of Health Care staff hope to identify and participate in opportunities to further the goals of MCH.

6. Maintaining strong relationships with medical providers and other health care professionals has remained a priority and has been possible to work on in this last year. This has come in the form of maintaining the community advisory committees for Newborn Metabolic and Newborn Hearing Screening as well as presenting potential regulation changes and Medicaid program changes. Breast and Cervical Health Check, family planning and specialty clinics also continue to promote strong links to community-based providers.

7. Finally, strong ties to other community agencies have become very important. Significant time is spent collaborating with the March of Dimes, the All Alaska Pediatric Partnership, and the Success by Six project focused on kindergarten readiness.

As the next year unfolds and DHSS staff begins to become established in their new roles, we are confident more collaboration will occur within the department. //2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

HSCI#1 The rate of children hospitalized for asthma (10,000 children less than five years of age). Alaska does not have legislation allowing the collection of hospital discharge billing information. As a proxy, we examined Medicaid billing information. In 1998, 246 of 10,541 hospitalizations among children less than 5 years were billed to ICD-9 codes 493.0-493.9 (proportion = 233 per 10,000 admissions). The proportions for Natives and non-Natives were 255 and 205 per 10,000 admissions, respectively. The HP2000 objective for the US is 50 per 10,000 admissions. Because asthma admissions may be billed for under ICD-9 codes other than those evaluated, it is likely that the reported numbers represent a lower limit.
/2002/The most recent available data for this indicator showed a substantial decrease in the rate of hospitalization for asthma among Medicaid eligible children over that reported for CY 1998. This indicator was incorrectly reported last year as the rate of hospitalization for asthma per 10,000 hospital admissions. The correct figure for FY1999 is 40 hospitalizations for asthma per 10,000 Medicaid-eligible children under 5.
/2003/ This year we further refined the reporting on this indicator to better reflect the asthma hospitalization rate. The numerator is the number of unduplicated Medicaid children that were hospitalized for ICD-9 Codes: 493.0 - 493.9 during SFY2000. For FY00 there were 126 Medicaid-eligible children that were hospitalized for asthma, which gives a rate of 50.5 (126/24,929) per 10,000 Medicaid-eligible children, a slightly higher rate than reported last year.
/2004/ The rate for FY00 is updated to 60.3 hospitalization per 10,000 Medicaid-eligible children under the age 5. The rate of hospitalizations is 69.3 per 10,000 for FY01. Alaska's rate of hospitalization for asthma within this population has increased approximately 9% from FY00 to FY01.
/2005/ The methodology for reporting this indicator was changed this year. For comparability and consistency, data for years 2000-2002 have been reanalyzed and updated using the new methodology. Years prior to 2000 have not been changed due to access limitations in the Medicaid database, caution should be used in comparing those years to data after 1999. The methodology change has been documented in the technical notes.
The revised rates for 2000 - 2002 are 53.4, 43.4 and 44.6 per 10,000. The rate for 2003 is 48.2 per 10,000. Although there was a significant drop in the rate of asthma hospitalizations from 2000 to 2001 (nearly 20%), it has increased 8% from 2002 to 2003. Compared to 2000, the rate in 2003 declined approximately 10%. Data for Health Systems Capacity Indicator No. 1 "rate of children hospitalized for asthma" comes from the Medicaid Information Management System (MIMS), Services, Tracking, Analysis and Reporting System (STARS) independent hospital claims (CH) table. Claims classified within the CH table include inpatient hospitalization services and do not include claims for outpatient hospital/clinic, day treatment or emergency visits where the client was not admitted for inpatient services. Data reported for this indicator include claims for asthma which were adjudicated and paid by Medicaid. See the technical note concerning the change in personnel and the resulting new methodology for calculating these rates.

HSCI#2 The % of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.
/2004/ The % of Medicaid enrollees whose age is <1 year and who received at least one initial or periodic screening remains unchanged. Approximately 82% of eligible infants received at least one initial or periodic screening during FY00, FY01 and FY02.
/2005/ This measure increased to 83.1% in 2003 - 1.6% increase from 2002 (81.8%). This was not a significant change.

HSCI#3 The % of State Children's Health Insurance Program (SCHIP) enrollees whose age is

less than one year who received at least one periodic screen.
Alaska collects Medicaid billing data. During 1998, 3,822 of 5,028 children enrolled in Medicaid received at least one initial or periodic screen (proportion = 76%). During 1998, 65 of 112 (58%) children enrolled in CHIP received at least one initial or periodic screen. For Medicaid enrollees, the HP 2000 objective for the US is 100%.
/2003/ The % of SCHIP enrollees under age one who received at least one initial or periodic screen increased in 2001 to 81.6%. Since SCHIP guidelines have been in effect, the number of SCHIP enrollees that received an initial or periodic screen before the 1st birthday has increased 30.6%.
/2004/ The % of SCHIP enrollees under age one who received at least one initial or periodic screening decreased from 82% in FY01 to 80% in FY02.
/2005/ In 2003 there was a significant decline (28.6%) in this measure, compared to 2002. The % dropped from 79.6% in 2002 to 56.8% in 2003.

HSCI#4 The % of women (15-44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on Kotelchuck Index.
Birth certificates from the AK Bureau of Vital Statistics provided this information. Birth certificates may be an inaccurate source of prenatal care since this information may not be available to the person completing the birth certificate. During 1998, 8,634 of 9,920 (87%) of women 15-44 with a live birth had an observed to expected prenatal visits ratio of at least 0.80. The HP2000 objective for the US is 90%.
/2002/This indicator was incorrectly reported in the narrative for CY 1998 as 87%. It should have been 74.6% (7401/9922) in 1999. The proportion of women who had an observed to expected prenatal visits ratio of at least 0.8 (75%) showed no improvement; in fact, adequacy of prenatal care has been declining since 1994. Adequacy of prenatal care did not improve with Medicaid expansion. We have not identified any changes in measurement or recording of prenatal care that can account for the decline in this indicator.
/2003/ Trend analysis for the years 1995-2000 shows a statistically significant decline in prenatal care participation, with an annual decrease of 1%. (Prenatal care indicators were updated this year to exclude women with unknown prenatal care histories from the denominator used to calculate the level of prenatal care initiation.)
/2004/According to the AK Bureau of Vital Statistics approximately 75% of women age 15-44 with a live birth during CY2001 met the intermediate adequacy criteria of greater than or equal to 80% of observed to expected prenatal visits. This is a decline of 1.2% from CY2000.
/2005/ There has been no improvement in this indicator - the percentage continues to decline and is at an all time record low since 1995 (72.8% for 2002). Compared to 2001, there has been a decline of 2.9%

HSCI#5 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.
5A. The % of LBW infants by Medicaid payment status: While 6% of all infants were born LBW (<2500 g), 7.5% of infants whose birth was billed to Medicaid were low birth weight compared to 4.9% of non-Medicaid births. The HP 2000 objective is <5% for all births; no objective has been set for Medicaid births.
/2002/ Data for Core Health Status Indicators 6A-6D is reported as single year data, so these measures showed moderate fluctuation between 1998 and 1999.
/2003/ The percent of LBW births from the Medicaid population was almost twice (1.89 times) that of the non-Medicaid population for 2000. For 1999, the disparity between these two groups was 1.52. The increase in this disparity reflects the decrease in the % of LBW births in the non-Medicaid group - there was no change in the % of LBW in the Medicaid group. (Note: While there appears to be a large disparity between these two groups, caution should be used when drawing conclusions or making inferences, since these rates reflect only two years of data and are dealing with small group sizes.)
/2005/ Although the disparity between LBW births in the Medicaid and non-Medicaid populations decreased approximately 16% from 2000 to 2002, LBW births are 1.59 times more common in the Medicaid population (7.0% vs 4.4% for Medicaid and non-Medicaid,

respectively). Overall, LBW births increased 5.2%, with no change in the Medicaid population. The increase is due to a 19% change in the non-Medicaid population. (Note: Caution should be used when drawing conclusions or making inferences, since these rates reflect only two years of data and are dealing with small group sizes.)

5B. Infant deaths/1000 live births by Medicaid payment status: In 1998, the overall infant mortality rate was 5.8 per 1000 live births. This outcome was concentrated among Medicaid recipients who had an IMR of 7.5 compared to 4.5 per 1000 live births among non-Medicaid recipients. In 1995, the overall US IMR was 7.5 per 1000 live births, with large differences among different racial groups. The HP 2000 objective is <7 per 1000 live births.
/2002/ Infant death rates improved for non-Medicaid recipients, but not for Medicaid recipients in 1999. Alaska's small population size should be taken into account when interpreting year-to-year differences in infant death rates.
/2003/ The infant death rate in the Medicaid group was almost three (2.76) times that of the non-Medicaid group for 2000. The infant death rate per 1,000 live births in the Medicaid group increased between 1999 and 2000, from 7.8 to 9.4 per 1000. (Caution should be used when drawing conclusions or making inferences from these two data points, since these rates reflect single years of data and are dealing with small group sizes.)
/2005/ The disparity in the infant death rate between the Medicaid and non-Medicaid populations declined 32% from 2000 to 2003. Infant deaths in the Medicaid population are 1.89 times that of non-Medicaid. For the Medicaid population, the rate declined 25.5% from 2000 to 2003 (9.4 and 7.0 per 1,000 live births for 2000 and 2003, respectively). In Alaska, IMR is analyzed using 3 or 5-year moving averages, due to small number of events and random fluctuations that occur when examining single-year rates. Caution should be used when drawing conclusions or making inferences from these two data points, since these rates reflect single years of data and the decline is most likely an artifact of this.

5C. The % of pregnant women entering care in the first trimester by Medicaid payment status: During 1998, 82% of all pregnant women entered care during the first trimester, compared to 75% of Medicaid recipients and 86% of non-Medicaid recipients. During 1995, 81% of pregnant women in the US entered care during the first trimester. The HP 2000 objective is >90%.
/2002/ There was a slight reduction in the % of women who received early prenatal care in 1999. Overall, 78.4% of pregnant women entered during the first trimester. 73% of Medicaid and 83% of non-Medicaid women sought early prenatal care.
/2003/ Overall, 80.5% of women entered care in the 1st trimester during 2000. 74% of Medicaid recipients compared to 87.4% non-Medicaid recipients began early prenatal care. Comparing the proportions of pregnant women in these 2 groups who did not receive prenatal care in the 1st trimester (26% for Medicaid and 13% for non Medicaid recipients), we see that late initiation of prenatal care is twice as common among Medicaid women. Women with unknown prenatal health care history were excluded from the denominator when calculating the percentage for 2000.
/2005/ There has been no change in the status of early prenatal care for Medicaid and non-Medicaid pregnant women in 2002, and the overall prevalence of receiving prenatal care in the first trimester also remains unchanged (80.5%). Late initiation of care is still twice as likely in Medicaid than non-Medicaid recipients (25.2% and 12.9%, respectively).

5D. Percent of pregnant women with adequate (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) prenatal care by Medicaid payment status:
During 1998, 67% of all pregnant women had adequate prenatal care compared to 59% of Medicaid recipients and 72% of non-Medicaid recipients. The HP2000 objective is >90%
/2002/ This indicator was incorrectly reported in 1998. We re-analyzed 1998 data using the above definition of adequacy of prenatal care and found that 74.6% of women overall, 78.4% of non-Medicaid and 69.3% of Medicaid women received adequate prenatal care in 1998. Despite the inclusion of pregnant women in Denali Kid Care, about the same proportion of Medicaid women (68.5%) received adequate prenatal care in 1999. Findings for the overall and non-Medicaid populations were also similar (75% and 81% respectively in 1999). Prenatal care

issues must be addressed in Alaska to better understand whether adequacy of prenatal care is a measurement issue or a true problem in service delivery.
/2003/ Although there was an increase in the % of pregnant women receiving adequate prenatal care in the Medicaid group from 1999 to 2000 (68.5 and 73%, respectively), there remains a disparity between the Medicaid and non-Medicaid groups. The % of pregnant women in the Medicaid group with inadequate prenatal care is 1.34 times that of the non-Medicaid group. (Caution should be used when drawing conclusions or making inferences, since these percentages reflect single years of data and are dealing with small group sizes. Figures for prenatal care were updated for all years by excluding women with unknown prenatal health care history from the denominator.)
/2005/ The disparity between Medicaid and non-Medicaid recipients has not significantly changed from 2000 to 2003 (69% and 77%, respectively). Overall, the percent of pregnant women receiving adequate prenatal care declined nearly 5% - declines of 5.5% and 3.5% for Medicaid and non-Medicaid recipients, respectively.

Summary of Health Systems Capacity Indicator #5: For all measured outcomes, Medicaid recipients fared 40-80% more poorly than non-Medicaid recipients. See attached bar graph.
/2005/ See attached bar graph.

HSCI#6 The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0-1), children, and pregnant women.
During 1999, the % of poverty level for eligibility in Medicaid and CHIP (Denali KidCare) programs are reported in the attached table. The HP 2000 objective for the US is that no American will have a financial barrier to receiving the screening, counseling, and immunization services recommended by the US Preventive Service Task Force.
/2003/ The data reported in the previous table is no longer accurate. Note the following changes: the % of poverty level to be eligible for Medicaid is 133% for infants, children and pregnant women. SCHIP expanded these numbers to 200% of poverty for all 3 groups.
/2004/ FY2000 percent of poverty for eligibility in Alaska's Medicaid and SCHIP programs was not accurately reported in the 2003 MCHB Title V Block Grant Application. Data on the percent of poverty level for coverage by Medicaid and SCHIP is now obtained from the AK Division of Medical Assistance that administers these programs. The actual % of poverty for coverage by Medicaid and SCHIP for FY00, FY01 and FY02 is the same as FY03. With the implementation of Denali KidCare (SCHIP) in 1999, the ceiling for Medicaid eligibility (Title XIX and Title XXI) was raised to 200% of the Federal Poverty level for children and pregnant women with the exception of children above 150% of federal poverty who have other health insurance who are not eligible for coverage.
/2005/ For children age 18 and under in the Medicaid Expansion Program for SCHIP, Denali KidCare, for the period October 1, 2002 - August 31, 2003 the FPL guideline was 200%. Effective September 1, 2003 the FPL guideline for children age 18 and under in Denali KidCare was lowered to 175%, and frozen at the 2003 FPL guideline standard. For pregnant women, for the period October 1, 2002 - August 31, 2003 the FPL guideline was 200%. Effective September 1, 2003, the FPL guideline for pregnant women was lowered to 175%, and frozen at the 2003 FPL guideline standard.

HSCI#7 The % of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.
Data for this indicator come from Medicaid Services and EPSDT. The % of EPSDT eligible children aged 6-9 years who received any dental services during 1998 was 42% (5,950 of 14,057). No HP 2000 objective for this indicator exists. Two related objectives aim to reduce the proportion of children 6-8 years of age with one or more caries and with untreated caries to less than 35% and 20%, respectively.
/2002/ When the new dental health program manager is on board, a needs assessment and survey will be conducted to further address this area.
/2003/ An examination of this indicator over the last 3 years shows annual incremental improvement, with about 50% of EPSDT children receiving dental services during SFY 2001.

/2004/This indicator continues to show incremental improvement with approximately 52% of EPSDT children receiving dental services in SFY2002, showing an approximate 2% increase from SFY2001.
/2005/ There has been no significant change in this indicator - 51.6% and 51.9% for 2002 and 2003, respectively.

HSCI#8 The % of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program.
In Alaska, all SSI beneficiaries less than 16 years requesting rehabilitative services from the state CSHCN program are eligible for Medicaid. Further, Medicaid covers rehabilitative services for all eligible children (age 0-21) who are SSI beneficiaries. Even as Medicaid is expanded to the 200% of poverty level in Alaska, MCFH anticipates that this population will continue to be covered by Medicaid for rehabilitative services, thereby maximizing the use of Title V to fund other programs/services for CSHCN who are without alternative resources.

HSCI#9A The ability of States to assure that the MCH program and Title V agency have access to policy and program relevant information and data.
/2004/Alaska's MCH data capacity is improving. The state is currently working on obtaining hospital discharge data, though this will not be an MCH responsibility. We are also working on linking newborn screening data with birth certificates. In FY04, MCH will be linked with Medicaid under the new Division of Health Care Services and may have improved access to paid claims information.
/2005/ Although not at the desired 90% of in-state discharges, the Hospital Discharge Database is now available. The tribal hospitals other than ANMC are not in the database at this time - the database has approximately 85% of all discharges statewide to date. Basset Army Hospital and API are not included. We have access to some summary data from the RPMS system about the native system discharges.

HSCI#9B Data for this indicator are from the Youth Risk Behavior Survey. In AK, 37% of children in grades 9-12 reported using tobacco during the previous month. No specific HP 2000 objective exists for this indicator. A related objective aims to reduce the initiation of smoking by children/youth so no more than 15% have become regular cigarette smokers by age 20.
/2002/ 34% of adolescents in grades 9-12 report using tobacco products in 1999.
/2003/ The 1999 estimate was updated to show that 37% of 9-12th grade students report using tobacco products.
/2005/ The 2003 Alaska YRBS is available this year. This is the first year since 1995 that Alaska has had a meaningful YRBS. The 1999 survey did not include Anchorage and was not representative of the state. Compared to 1995, current tobacco use among 9-12 graders dropped significantly - from 36.5% to 19.2% in 2003 (a decline of 47%).

HSCI#9C
/2004/AK does not conduct statewide surveillance of overweight/obesity of children. Data is available through WIC, RPMS and some school districts. The state received special federal funding in 2002 for a statewide "Obesity Project" and is developing systems for monitoring childhood obesity through the Division of Public Health.
/2005/ No update.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Section of Maternal, Child and Family Health has developed great capacity in terms of programmatic and population-based data analysis and surveillance activities for MCH-related programs. The MCH Epidemiology Unit has been a key group in terms of supporting the MCH Block Grant requirements and initiatives of the Section, and providing the basis of accountability required by GPRA. Activities of the MCH Epidemiology Unit focus on providing reliable data through our findings and analyses to aid in program evaluation, needs assessment and policy/decision making regarding the MCH population in Alaska.

One of the priorities during FY2003 and FY2004 is to make our data and analyses available to policy makers, public health professionals, health care providers and the community through the first edition of the Alaska MCH Data Book, Maternal and Child Health Fact Sheets, Family Health Dataline publications and our website. We will continue to make this a priority in FY2005 as well.

The Alaska MCH Data Book, completed in FY2003, is intended to serve as a reference guide for statistical and epidemiological information for use in program planning and decision-making. It provides critical data on leading health status indicators and emerging issues in maternal and child health. The data book will be distributed in hard copy and also available to download from the MCH Epidemiology website. MCH Fact Sheets are produced in hard copy and available to the public on our website. These one-page publications provide quick, easy to read information on findings and analyses from our surveillance programs. Family Health Datalines are produced in hard copy and available to the public on our website. These several-page publications provide more in-depth analyses than our MCH Fact Sheets and are more data/statistically oriented.

A major accomplishment during FY2003 and on-going into FY2004 is the addition of accessible data to the MCH Epidemiology website from our surveillance programs. During FY2004 we will be focusing on a dynamic data web site that will allow users to query data tables for leading health status indicators in the MCH population.

In FY2005, an MCH data book focused on Alaska specific PRAMS data will be published. In addition, further enhancements to the web site will be taking place in an effort to support access to the MCH data by a wide audience.

B. STATE PRIORITIES

MCFH established its goals and performance measures based on the priority needs which were developed from its five-year statewide needs assessment. Focus for MCH issues has been and will continue to be on prevention and early intervention services related to areas such as family violence, child abuse and neglect, young children's behavioral health and reduction of unintended pregnancy. MCH will continue to rely upon the MCH EPI staff to support programs and monitor activity effectiveness through its development and implementation of data systems and analysis of relevant data.

Approximately ten years ago, MCH priorities were determined based on a review of MCH data by a medical epidemiologist. A group of community representatives and experts, related to the specific areas of identified need, was then brought together to serve as an advisory group regarding determined priorities. This was important since many of the identified priorities for Alaska did not match identified national priorities. We continue to track these priorities and indicators through our five-year needs assessment process and to bring a group of advisors together as part of this process. The Maternal, Infant Mortality Review (MIMR) is an example of one initiative that developed out of state-identified needs. The team of experts that supports the MIMR was established to address post-neonatal mortality issues (state priority #7) and has provided information to programs on areas identified for public education, for example, to help reduce post-neonatal mortality. Children's behavioral health was identified as a priority (state priority #3) through anecdotal evidence and related

indicators; parents, caregivers, service providers and the medical community brought this issue forward to the Section. Children's behavioral health continues to be a priority need in the state. The Division of Behavioral Health will be responsible for this area under the state's FY04 reorganization.

State priority need #1 (reduce the rate of drug use among families, primarily alcohol intake and cigarette use) relates to State Performance Measures 3 and 4 (percentage of women who smoke prenatally and percentage of women who drink prenatally). While the Section of MCFH has no programs that directly address the issues of alcohol and cigarette use among families, the Healthy Families Alaska home visiting program, for example, has addressed these issues among participants, primarily through referrals. In addition, the MCH EPI unit collects and analyzes data through its FAS Surveillance and Pregnancy Risk Assessment Monitoring activities and collaborates, for example, with the state FAS program by providing data to be used in program planning.***/2005/These data analysis activities have continued this fiscal year as well //2005//***.

Priority need #2 (reduce the rate of child abuse and neglect) relates to State Performance Measure #2 (rate of substantiated reports of harm to children). Activities of MCH programs which address this issue include the Healthy Families Alaska home visiting program and the Family Violence Prevention Project. ***/2005/No change. //2005//***

Priority #3 (increase public awareness and access to services for children's behavioral health issues) relates to State Performance Measures #2 (rate of substantiated report of harm to children) and #7 (percentage of people experiencing intimate partner violence during their lifetime), and National Performance Measures #2 (percent of CHSCN whose families partner in decision-making at all levels and are satisfied with the services they receive), #3 (percent of children with special health care needs who receive coordinated, ongoing, comprehensive care within a medical home), #4 (percent of CSHCN whose families have adequate private and/or public insurance to pay for the services they need), #5 (percent of CSHCN whose families report the community-based services system are organized so they can use them easily), and #16 (the rate of suicide deaths among youths 15-19) because this state priority does not have a specific performance measure tied to it. Activities in support of it are discussed here.

A state partnership on Early Childhood Mental Health planning project was founded on the premise that healthy social and emotional development during the critical years of birth to six results in improved developmental outcomes, productivity and well-being over a lifespan and intergenerationally. As in many other states, Alaska is plagued by a lack of mental health practitioners experienced in early childhood. However, the absence of a road system, vast geographical area, and geographic isolation of Alaska's remote villages gives rise to special challenges. As a result, access to mental health services for children in this age group and their families in Alaska is conspicuously limited or absent.

The state Partnership has outlined the gaps and barriers that hinder access to appropriate mental health services. It is clear that one barrier is a general lack of awareness that very young children can have mental health concerns. One step, then, is to educate the public and policy makers about the significance of helping families and caregivers foster positive social and emotional health in young children. A second important step is forming a public and private partnership aimed at developing shared responsibility for improving the social and emotional health of young children. The state partnership involves our social services, governmental, corporate, political, educational, faith, and health care systems. This group was briefed on key national research findings and recommendations and received an overview of existing state plans that pertain to early childhood behavioral health. A needs assessment was planned in order to document strengths and challenges of the system respective to children birth to age five, and an action plan will be developed.

The aim of efforts led through MCFH has been to broaden responsibility beyond the governmental sector for public awareness, funding, and problem solving. The interagency partnership developed an action plan to generate innovative ideas that engage these and other partners in creating early environments for children that maximize their mental health. Because Alaska's barriers and gaps in

services for young children are sizeable, the strategies will be a model for other states with remote and frontier communities.

Four statewide Behavioral Health Institutes were held between 2001 and 2003 and were attended by early intervention providers, community mental health providers, child care and Head Start staff, Parents as Teachers, private providers, public health nurses and child protective services staff. In March 2002 the third Institute had Jan Martner of Arizona as the guest speaker, with several Alaskan speakers offering breakout sessions. Topics covered at the third Institute included assessment tools, treatment strategies, positive behavior support, red flags and referrals, and a diagnostic classification system for infants and toddlers. This Institute also featured a description of efforts undertaken at the local level to address the behavioral health needs in the early childhood population. Total attendance at the third Institute was 171.

The third Institute was attached to the Early Years, Critical Years conference, which also featured a behavioral health strand. Topics related to behavioral health that were presented at the Early Years conference included early brain development, the media and public policy; child parent interaction therapy; infant mental health; motivational interviewing; and asset building in young children. The total number of people attending the Early Years Conference was 473. The 4th and last Institute was held in April 2003. The total number in attendance was 261.

A training and consultation program for young children's behavioral health was established. Infant Learning Programs were offered funding to use for training and/or consultation and seven funding requests were received and approved. Collaboration with other providers was encouraged. Some programs used funding to contract mental health consultants, while others organized training.

The Children's Behavioral Health Program Coordinator has been working with a collaborative project among Tlingit/Haida, an early intervention agency in SE Alaska, and the National Association for the Education of Young Children in Southeast Alaska. They received an Early Learning Opportunities 17-month grant from the Child Care Bureau to plan and implement training and research system development to improve the access and availability of mental health services in Young Children. These efforts closely parallel the activities of the statewide project, but are limited to southeast. The Program Coordinator has participated on the Regional Advisory Committee to assist with their efforts and maximize opportunities for replicating successful models.

A project scoping sheet was submitted to Division directors in DHSS outlining issues that had been raised by providers and parents. These included appropriate diagnostic instruments and categories, billing issues around Medicaid, and the ability to provide in-home rather than clinic-based services for young children. Although at this time, no action is planned that requires funding, the scoping sheet also outlines issues that may be addressed without the need for additional dollars and documents others that may be researched further at a later time.

Like many other states, Alaska is noting an increase in the numbers of children with autism. Typically these children experience very challenging behaviors, and require early intervention to ameliorate the behaviors. In an interdepartmental effort, Maternal, Child and Family Health has collaborated with the Governor's Council on Disabilities, the Division of Mental Health and Developmental Disabilities and the department of Education and Early Development to host an Autism Summit in April 2002. The Summit brought together parents, providers and state representatives to outline concrete steps that can be taken to improve services for this vulnerable group.

The Program Coordinator developed a small library of publications related to early childhood mental health and has researched what other states are doing to address early childhood mental health. The Program Coordinator also worked with a planning committee to organize a Northwest Initiative to advance the Surgeon General's Action Agenda on children's mental health. This involved a multi-state conference in the fall of 2002.

In the DHSS reorganization effective 7/01/03, the Children's Behavioral Health Coordinator position

was eliminated. It is anticipated that the new Behavioral Health Services Division will assume responsibility for early childhood mental health issues.

As a result of diminished capacity to address children's behavioral health awareness and access issues after FY03, CSHCN initiatives will address this priority and related national performance measures; the family violence prevention project has worked on projects related to child witnesses; and the Adolescent Health program has promoted Youth Developmental Assets to address adolescent risk behaviors.***/2005/Work in the area of Children's behavioral health has been limited this last fiscal year. //2005//***

Priority #4 (reduce the rate of unplanned and unwanted pregnancies including teen pregnancies) relates to State Performance Measure #1 (percent of unintended births). The MCH capacity to address this issue has varied over the years with changes in funding availability. We currently support family planning and abstinence education activities.***/2005/ No change.//2005//***

Priority #5 (increase access to dental health services for children) relates to National Performance Measures 9 (percent of third grade children who have received protective sealants on at least one permanent molar tooth) and 14 (Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program). The state's MCH capacity to identify and address oral health issues has improved significantly with the availability of CDC grant funding.***/2005/ Significant progress has taken place this last year with the development of an oral health steering committee. A contract to conduct a baseline assessment of 2300 3rd graders across the state has been awarded. This will provide the state oral health programs with a baseline measurement of oral health status that will assist in further development of the state oral health plan.//2005//***

Priority #6 (reduce the rate of domestic violence) relates to State Performance Measures 5 (percentage of women experiencing physical abuse by husbands/partners surrounding the prenatal period) and 7 (percentage of people experiencing intimate partner violence during their lifetime). The MCH capacity to address these issues is primarily through its Family Violence Prevention Project.***/2005/No change.//2005//***

State priority #7 (reduce the rate of postneonatal mortality) relates to state performance measure #6 (percent of mothers putting their infant down to sleep on their backs) and national performance measures #1 (percent of infants screened for conditions mandated by the state newborn screening program), #3 (percent of children with special health care needs - CSHCN - who receive coordinated, ongoing care within a medical home) and #4 (percent of CSHCN whose families have adequate private and/or public insurance to pay for the services they need). The state MCH program's capacity to address this priority has been through its newborn screening program, CSHCN activities, review of epidemiological data and information from the Maternal Infant Mortality Review which is provided to programs, health care providers and communities for program planning and education that focus primarily on prevention-related activities such as the Back to Sleep and Never Shake a Baby campaigns. This issue has been heavily focused on over the last couple of years. The state has actively engaged all of the birthing facilities to participate in the national education campaign around many of these issues.***/2005/Work programatically has been more limited as a result of the changes experienced with the reorganization, however many facets of the work have prevailed. Ongoing work re-establishing relationships and prioritizing the work to be done by a much smaller staff will occur in FY2005. //2005//***

Priority #8 (reduce the rate of teen suicide) relates to State Performance Measure #10 (percentage of youth who feel supported at school) and National Performance Measure # 16 (the rate of suicide deaths among youths 15-19). MCFH capacity to address these issues is through its adolescent health program, promotion of Youth Developmental Assets, and collaboration with other agencies and organizations.***/2005/ The focus of this work changed considerably and has transferred to the Division of Behavioral health as the Adolescent Health Coordinator position has gone away. Teen suicide prevention is a priority issue in the current administration with a dedicated staff***

assigned to work on it. Involvement of MCH staff has been limited.//2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

The percent of infants screened in the State in 2003 was 99.7%. Significant efforts conducted by the manager reduced those cases lost to follow up to less than 0.5%. This work focused particularly on tracking premature and sick infants hospitalized for long periods in the state's level III newborn intensive care unit.

The Newborn Metabolic Screening Advisory Committee took the time during the year to examine the pros and cons in the literature about increasing the number of metabolic screens conducted to 30 from 6. Expanding the numbers of disorders screened necessitated a change in methodology to tandem mass spectrometry. As Oregon Public Health Lab, the state's contractor for metabolic screening, was already moving in this direction, the Newborn Metabolic Advisory committee concurred and supported the expanded testing panel. This action necessitated a change in the state's fee regulation outlining the maximum amount that could be charged for newborn metabolic screening. While the decision was made to implement expanded testing on July 1, 2003, the fee regulation was not signed into regulation until September. Thus, a new timeline was developed to begin testing on October 1, 2003.

In preparation for the expanded testing, the program manager began a series of educational efforts around the state targeting medical staff involved in the collection process. These efforts included education on proper collection techniques, transport issues, and how to reduce the number of hospital discharge refusals. In an effort to attract medical providers to attend, the program manager offered continuing education credits. As a result of the education conducted with hospital staff, discharge-screening refusals fell to near zero in most communities.

These activities are both infrastructure building and population-based services.

b. Current Activities

With the implementation of expanded testing using tandem mass spectrometry on October 1, 2003, the state tests for over 30 conditions that could adversely affect an infant's health and mental growth. The state began to test all babies for abnormal hemoglobins on this date as called for in the standards set by the American Academy of Pediatrics. Prior to October 2003, this testing was done on a voluntary, test requested basis. Ongoing educational efforts are underway to address the issues of proper collection and lab submission for confirmatory testing. Targeted education and communication has been directed with providers who have high refusal rates. A brochure for prenatal clients was developed and piloted with parents and low literacy readers. It is presently being distributed throughout pediatric, family practice and obstetric offices, public health and community health centers and childbirth education offices across Alaska. Finally as part of the broader community education, the program manger has participated in radio talk shows and presented at the University of Alaska medical and laboratory assistant's classes. These activities are direct health service, enabling and population-based services.

Follow-up tracking and referrals were streamlined this year to expedite diagnostic testing for any newborns screening positive. All infants identified with PKU, MCAD, and CAH were referred to and participated in the Genetics and/or Metabolic Clinic conducted by the State of Alaska. The children with PKU receive more frequent monitoring through phone support with

the contractor. Those with MCAD and CAH receive genetic counseling and advice on their child's disorder. All of these conditions are reportable to the Birth Defects Registry and information is provided to the registry. These are direct health and enabling services.

The Newborn Metabolic Screening advisory committee has met on a regular schedule, expanded its membership to include sub specialists in perinatal medicine, pediatric endocrinology and hematology and now has a physician chair. Some policies are under development including addressing what situations would allow blood spots to be used for further testing during the three years they are stored. In addition, educational presentations are a regular part of the meeting. Topics covered to date include ethics and screening, CAH, and tandem mass spectrometry instrumentation. These are infrastructure-building activities.

c. Plan for the Coming Year

Educational information will be developed for providers regarding the less well-known conditions identified through expanded testing with tandem mass spectrometry. Included in this education will be information on the confirmatory testing process including proper specimen collection and shipment to the appropriate testing facility. Guest speakers will be invited to the Newborn Metabolic Advisory Committee meetings to discuss what some of the screening results mean and if/how to treat infants identified with these disorders. Integration of newborn metabolic screening data with the software database to be purchased by the Early Hearing Detection and Intervention program will also be evaluated. Finally, further work with Oregon Public Health Laboratory and Seattle Children's Hospital and Regional Medical Center will be conducted to clarify roles and streamline the process of confirmatory testing, counseling and medical care for newborns with suspected metabolic disorders.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

In February 2003, a 2-day CSHCN summit was convened. The overall goal was to work together to build a system of care for children with special health care needs in Alaska so that the six core outcomes for CSHCN would be achieved. The Summit was a collaborative event sponsored by the Stone Soup Group, a family-to-family organization, the Alaska Native Tribal Health Consortium (ANTHC) and the Alaska DHSS, DPH, MCFH. Funding from an American Academy of Pediatrics Medical Home grant (received by a physician at ANTHC), the Alaska Mental Health Trust Authority and in kind contributions from the Stone Soup Group and MCFH supported this important work. Approximately 60 individuals, including parents and family members, health care providers, and many public and private partners participated. The 2-day planning meeting used the Tri-regional model that included a panel presentation followed by group work to identify strengths, needs and strategies for each of the 6 outcome areas. Written proceedings and plans were finalized and distributed to all who participated. The key issue/challenge identified by parents for NPM#2 is that parents and providers are two very important ingredients to create change and to improve services. The overall recommendation is that families need to be involved at all levels of planning and service delivery. Initially in FY03, the steering committee for the CSHCN summit continued to meet and discuss the "Champions for Progress" grant opportunities that were available. A brainstorming session ensued in the fall of 2003 and projects were identified. Unfortunately, stakeholders and/or interested parties were too overwhelmed with the results of the re-organization of DHSS to participate in the application for these funds for the first two rounds of funding availability. Activities in this area are infrastructure building for the CSHCN population.

b. Current Activities

Genetic counseling is conducted as a non-directive process. Parents are provided with information about the disorder, testing, and recurrence risk to future pregnancies but make their own decisions about reproduction, testing and suggestions for care. Support to parents is provided in several ways. Parents are supported in the following ways: Patients are provided with a medical report summarizing their genetics clinic visit, and follow-up letters with laboratory results for tests completed; parents are provided with information about national (disease specific) support groups, local parent contacts, pen-pals, internet chat rooms, and local support organizations such as Stone Soup; patients are referred to other state specialty clinics such as cleft lip/palate and neurodevelopmental for coordination of specialty care; and to other state programs such as newborn hearing screening and Denali Kid Care for program information and eligibility; patients are referred to other service agencies, such as Muscular Dystrophy Association, Cystic Fibrosis Association, and Hemophilia Clinics for multidisciplinary specialty services; nutritional counselors work monthly with parents of children with metabolic conditions (PKU, galactosemia) to assure dietary compliance and monitor monthly blood tests; the genetic counselor works with families of children with metabolic conditions to arrange ordering of formula and specialty food, and assists them with trouble shooting insurance reimbursement problems as well as working with families to assure that children receive recommended school services, including meals that accommodate special dietary needs, psychosocial assessments, special classroom placement for hearing/vision impaired, and special education services. These activities are direct health care services and enabling services.

Cleft Palate Clinics encourage parents of CSHCN to become more involved in decision-making through the use of parent navigators from Stone Soup Group and their distribution of educational information. The services provided by Stone Soup Group are through a state grant using MCH block grant dollars. Parent navigators are parents of CSHCN and at present assist only with the Cleft Lip and Palate Clinic families. Parent navigators provide clinic preparatory and follow-up services for families who request their support, distribute resource materials, and facilitate peer support. They solicit feedback from families who attend state-sponsored clinics to determine their level of satisfaction. The state provides information packets about clefts to hospitals for distribution to parents of newborns with clefts. These activities are infrastructure and population based services.

c. Plan for the Coming Year

Work is underway to participate with Family Voices in supporting the application for Incentive awards available through the Champions for Progress Center. Their proposal to train more parent leaders in the areas of advocacy and parent navigation fits with the goals outlined from the CSHCN Summit held in 2003 (infrastructure and enabling services). In addition, we have recommended funding Stone Soup Group parent navigation services again for the coming year and they will expand their work with parents of Cleft Lip and Palate children to include a newsletter for parents, continuing education for providers and hospital visits to parents of newborns with clefts (infrastructure and population based services).

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

There are no pediatric geneticists in Alaska. To address this unmet need at the community level, HCS contracts with Children's Hospital and Regional Medical Center (CHRMC) in Seattle to conduct outreach clinics throughout the state. This contract includes services of clinical geneticists who offer diagnostic clinics for children and adults with genetic diseases, birth

defects, or persons "at risk" for genetic conditions because of ethnicity, family history or age. In addition metabolic geneticists and metabolic nutritionists staff metabolic genetics clinic for medical management of children and adults with inherited metabolic conditions, particularly children identified on newborn metabolic screening.

In February 2003 a CSHCN Summit was funded in part by an AAP Medical Home grant. Participants identified two key issues/challenges related to this outcome: 1) families and providers need to be aware of available services and resources for CSHCN and 2) there is a shortage of health care providers especially in rural areas. Overall recommendations related to these issues are: 1) consolidate and simplify information about services and resources and make it easily accessible to providers and families and 2) increase the number of health care providers in rural Alaska. Activities fall under infrastructure building and serve the CSHCN population.

b. Current Activities

MCH block grant funds and program receipts are used to support certain direct care services for children attending genetic services. No patients are refused services due to inability to pay. A sliding fee scale is provided based on poverty guidelines, and all third party providers (private insurance, Tri-care, Medicare, Medicaid, state CHIP programs, and Indian Health Service) are accepted (direct health care service). All patients referred to genetics clinic are required to have a medical home. The genetic counselor assists patients in obtaining a medical home if they do not have one already. This is usually a primary care pediatrician, a family practice physician, or a sub-specialist knowledgeable in management of a specific genetic condition. The genetics clinic is a consultative clinic and does not provide primary care. Reports summarizing the genetics clinic evaluation, which may include recommendations for care and further testing are sent to the primary physician. Geneticists are available to primary physicians for consultation or technical assistance. The genetic counselor works with local hospitals and CHRMC to assure that families are referred to appropriate community based genetics clinics following hospital discharge, or that families are aware and able to attend regional clinics (e.g. metabolic clinics) if a local clinic is not accessible. Finally, the geneticists and genetic counselor work with families to locate and refer to out-of-state medical centers for care if no instate resource is available. These are population-based, enabling and direct health care services.

Pediatric specialty clinics work with providers to assure that CSHCN receive care within a medical home. Since there is no craniofacial center in Alaska, the state coordinates clinics for children with facial clefts. A multidisciplinary team of health care providers is assembled who provide patient evaluations and long term treatment planning. Their recommendations are given to parents of the children they evaluate as well as their providers. The state also contracts with providers to offer pediatric cardiac, neurodevelopmental and neurology clinics in hub communities where these services would not otherwise be available. Paper Trails notebooks are provided to families of CSHCN as needed to assist in managing medical records. Continuing education is provided in the area of neurodevelopmental topics to staff at the rural public health center and to private providers. These activities are infrastructure, population-based and enabling services.

c. Plan for the Coming Year

With the implementation of tandem mass spectrometry for newborn metabolic screening in October 2003, additional metabolic disorders have been identified resulting in an increased demand for capacity and frequency of the newborn metabolic clinics. As a result, four additional clinic days will be added during the next state fiscal year with some of the clinic days offered in Fairbanks and Juneau or Bethel. MCH block grant monies will continue to be used in support of this effort (direct health care services). A decision was made to discontinue state-sponsored

pediatric cardiac clinics that have been offered only in the Southeast portion of the state. There are presently two pediatric cardiologists in Alaska with a third one joining their practice. All three are interested and willing to travel to smaller communities and provide services in conjunction with the cardiac surgeons. In addition, Seattle Children's Hospital and Regional Medical Center will continue the clinics privately without assistance from the state.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

The February 2003 CSHCN Summit participants identified two key issues/challenges in this area: 1) not all families with CSHCN have adequate insurance and 2) insurance systems are complicated and confusing for many families. Overall recommendations related to those issues are 1) families need to have affordable insurance for their CSHCH and 2) make simplified information about insurance centrally available to families for CSHCN. Summit activities fall under infrastructure building and serve the CSHCN population.

b. Current Activities

Insurance information is collected and tracked for all children accessing state-sponsored CSHCN services. CSHCN programs collaborate with the Denali KidCare program which provides Medicaid coverage to many CSHCN. A contract with the Alaska Native Tribal Health Consortium (ANTHC) provides IHS funds as payer of last resort for genetics and specialty clinics services. Genetics and specialty clinics services are provided regardless of inability to pay. These activities are infrastructure building, enabling and direct health care services.

c. Plan for the Coming Year

Current activities will be continued. The CSHCN program will collaborate with Medicaid to explore options for covering special feeding supplies for CSHCN with facial clefts. Depending on budgetary constraints, an option to buy into a high risk insurance pool for children who have special health care needs will be investigated.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

a. Last Year's Accomplishments

Participants in the February 2003 CSHCN Summit indicated that the key issue/challenge facing families is that accessing services is complicated and confusing. Overall recommendation is to increase access to care coordination. Summit activities fall under infrastructure building and serve the CSHCN population.

b. Current Activities

Genetics clinics provide an infrastructure for linkages with many different public and private agencies. These services include referrals for specialized medical assessment and/or medical care, psychometric testing for eligibility of special educational services, vision and hearing assessments, and local and national parent support groups. In addition, genetics clinics meet throughout the state in public health clinics and work with public health nurses at the

community level to provide clinic services, case management, and technical assistance to families and individuals. Annual reports are reviewed to assess attendance at specific clinic sites and practitioner referral patterns. This is to monitor service delivery and determine if sites are appropriate for changing population needs and access to care. Geneticists provide information, medical consultations and technical assistance to local physicians and health providers via MEDCON, telemedicine, Internet resources (http://www.genetests.org), and on-site continuing education presentations at grand rounds. This is particularly useful for providers in rural areas. The genetic counselor works with a newborn metabolic coordinator to ensure that infants with abnormal newborn screening tests are referred to the metabolic genetics clinics for ongoing care as quickly as possible after diagnosis is made. To assure culturally appropriate genetics counseling and accessible community services, genetics clinics are held at two Alaska Native Medical Care Facilities (Yukon Kuskokwim Delta Regional Hospital and the Alaska Native Medical Center). In addition, for our non-English speaking families, professional medically-trained interpreters translate the genetics session for the family. Information packets about the genetics condition are provided in their language if possible. Finally, lending libraries of audio-visual and print materials of genetic conditions are available to families on request. These are infrastructure building and enabling services.

In post Summit meeting with the steering committee, many ideas were considered in support of applying for a Champions for Progress Center Incentive Awards. Initially Stone Soup Group stepped forward to act as the primary agency to request the award for expansion of parent navigation services to the rural areas through a Train the Trainer model. Unfortunately, Stone Soup was not able to go through with this application due to their capacity issues.

c. Plan for the Coming Year

The Title V/CSHCN director plans to recall the CSHCN steering committee to prioritize the outcomes and priorities addressed in the CSHCN Summit held in February 2003 with the goal of working towards resolution on at least one issue in FY05. In addition, the state will be completing their five year needs assessment process which will help identify priorities. The Title V/CSHCN director also will continue to actively participate in the community coalition of hospitals and medical providers serving the pediatric population of the state, called the All Alaska Pediatric Partnership. This organization is again working on identifying pediatric specialty provider needs, developing a recruitment priority list and moving ahead in developing plans for pediatric systems of care in the areas of rehabilitation and cancer care in coordination with other Outside tertiary and regional medical facilities. These activities are infrastructure-building services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

The February 2003 CSHCN Summit identified the lack of a formalized system for transitioning from childhood to adult services as one of the key issues/challenges requiring systems to be developed to support transitions in the areas of health care, housing, employment and leisure activities. In support of this effort, staff from the Section of Maternal, Child and Family Health's, Children with Special Health Care Needs unit, participated in the Alaska Works Project which focused on training. They also provided support in the area of technical assistance to community providers and consumers as well as the Jobs Centers and Division of Vocational Rehabilitation (DVR) to improve collaboration. Representatives from the Jobs Centers and DVR participated in the policy portion of the CSHCN summit. These activities are infrastructure-building and serve the CSHCN population.

b. Current Activities

With the dismantling of the Section of Maternal Child and Family Health, the Unit that focused on Children with Special Health Care Needs was transferred to the newly developed Office of Children's Services whose primary focus is child protection. Staff positions were eliminated or vacant for most of the year and thus the focus of the remaining staff's work was limited to early intervention services. With the hiring of a new unit manager, discussions are underway for opportunities to collaborate with the Title V/Director of CSHCN whose position resides in the Division of Health Care services. These collaboration activities are infrastructure-building services.

c. Plan for the Coming Year

This next fiscal year will require staff to examine what the outcomes were from the Alaska Works Project and evaluate if lasting changes or capacity building activity occurred. Collaboration with the Office of Children's Services Child to Adult transition coordinator may also provide an opportunity to replicate a service model already under development for children who are "aging out" of state foster care and into adult programs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

a. Last Year's Accomplishments

The percent of Alaskan two-year-olds that are adequately immunized as defined by this Performance Measure returned to the FY 1999 level in FY 2002. The percent of adequately immunized two-year olds was 70.6% in FY 2000, 71.2% in FY 2001 and 75.3% in FY 2002. The Healthy Alaskans 2010 immunization baseline was 71%, compared to the national baseline of 73%; Alaska's target is 90% by 2010.

In August 2003, Alaska Immunization Program, Section of Epidemiology, and The Vaccinate Alaska Coalition received an "Excellence in Immunization" award. The National Partnership for Immunization gives these awards in recognition of innovative and effective childhood immunization awareness programs. Alaska was recognized for the "I Did It By TWO!" campaign which is a collaborative effort bringing together private and public health care providers, the Iditarod Trail Sled Dog Committee, other coalitions and professional organizations, private businesses and media outlets.

The MCH Epidemiology Unit published data related to Alaska's child immunization rates in the first edition of the Alaska MCH Data Book 2003.

b. Current Activities

During FY 2004, the Alaska Immunization Program worked to re-awaken local immunization coalitions around the state. The Anchorage Immunization Partnership initiated an outreach effort to new parents in the maternal-child units at the two private hospitals. Immunization Partnership members regularly visit the units to congratulate new parents in these units and offer them information about where they may take their children for immunizations. In addition, the Women, Infant and Child Nutrition (WIC) program began the process of reviewing immunization records for a key immunization indicator (DTAP). If incomplete records were found, referrals were made to immunization clinics and health care providers.

c. Plan for the Coming Year

The Alaska Immunization Program will work to increase the flow of immunization information to parents from the Healthy Families and WIC programs, both of which are now housed in the Office of Children's Services. The Immunization Program will also work with local Immunization Coalitions to increase media exposure for issues associated with vaccine-preventable diseases and immunizations.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

The trend of a decreased birth rate for teenagers age 15-17 between FY00 and FY01 further dropped from 24.3 births to 19.1. There was a slight increase in FY02 to 19.7; however Alaska has managed to meet its target of less than 23 births per 1000 for two fiscal years. Births where maternal age is unknown have been excluded from the denominator for this year and all previous years.

In FY03, MCFH continued to administer the federal abstinence grant which provided local school districts with funding to conduct the Postponing Sexual Involvement training to junior high and high school students (population-based services). This activity was transferred to the Office of Children's Services at the start of FY04.

In addition, family planning services were provided to teens at Family Planning Clinics statewide (direct health care service). Services include abstinence education and support parental involvement in contraceptive decision making. MCFH also continued to promote the Youth Developmental Assets framework to address adolescent risk behaviors (infrastructure building and population-based services). The Assets framework has been implemented in most schools statewide and the AK Association of School Boards is a strong partner in the implementation of the Assets framework.

The MCH Epidemiology Unit published data related to Alaska's birth rate in their first edition of the Alaska MCH Data Book 2003 (infrastructure building service). Finally, the Adolescent Health Coordinator provided frequent technical assistance to schools, businesses and youth serving agencies statewide (infrastructure building service).

b. Current Activities

With the reorganization and dismantling of the section of Maternal, Child and Family Health the Adolescent Health coordinator position was transferred to the Office of Children's Services with a planned change of focus to work on transition planning for foster children aging out of child protective services. The individual staff member transferred to the Division of Behavioral Health to work on their Youth Resiliency program beginning in January of 2004 and the Adolescent Health coordinator position has remained vacant since that time.

The MCH Epidemiology Unit, MCH Indicator Surveillance Project, is writing an MCH Fact Sheet on Alaska's teen birth rate and sexual behaviors among Alaskan high school students. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes data related to this indicator easily accessible and available on the MCH Epi website. These are infrastructure-building services.

Family planning with a focus on teens has continued at the statewide Family Planning clinics and abstinence remains one of the topics covered in their educational curriculum. It is unclear what is happening in the area of abstinence education at the present time. These are direct health care services.

c. Plan for the Coming Year

Dialog between the Deputy Commissioner for the Office of Children's Services and the Commissioner's office is planned to determine where the abstinence grant should be administered from. Family planning clinics will continue to offer information as part of their normal curriculum on pregnancy prevention.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

Information regarding the application of dental sealants in Alaska is monitored for children aged 8 and 9 years old enrolled in Medicaid/SCHIP (Denali KidCare, a Medicaid expansion). The information collected reflects the number of unduplicated children aged 8 and 9 years who received any dental sealants applied to secondary molars paid for by the Medicaid program during SFY2003. Reporting period and denominator methodology from 2000-03 have been revised for this indicator for 2005 BG submission. Historically, FFY (October through September) has been the report period; however this has been changed to SFY (July through June). Also, point-in-time estimates for the number of children eligible for Medicaid services during the FFY have been replaced with an actual count of 8 and 9 year old children who had an eligibility segment at any time during the SFY. Even with changes in eligibility requirements of the Medicaid program in Alaska over the past year, the rate of children who have received dental sealants has remained relatively constant.

The Division of Health Care Services provided a grant to the Southeast Alaska Regional Health Consortium (SEARHC) for travel support for pediatric dental teams to serve children enrolled in Medicaid/SCHIP (Denali KidCare) in Southeast Alaska. The project provided a total of 2,162 patient visits in FY2003; of which 1,990 patient visits were for children enrolled in Medicaid/SCHIP.

The division contracted for pediatric dental services for the Kenai/Soldotna region of the state. This project provided 1,039 patient visits in FY2003, of which 833 patient visits were for children enrolled in Medicaid/SCHIP. These two activities are direct health care services.

The Oral Health Program applied for grant funding from the Centers for Disease Control and Prevention (supplemental grant award) and the Health Resources and Services Administration (State Oral Health Collaborative Systems - SOHCS) to support an oral health screening of third-grade children from a sample of elementary schools using the Basic Screening Survey model developed by the Association of State & Territorial Dental Directors. Funding for the project was received this fiscal year.

The Oral Health Program receives funding for building infrastructure through a cooperative agreement with the Centers for Disease Control and Prevention, Chronic Disease Program. These funds supported the implementation of a water fluoridation monitoring program in collaboration with the Alaska Division of Environmental Conservation and the Alaska Native Tribal Health Consortium. Funds also supported the development of the oral health program web site and a health education exhibit, which includes dental sealant information for parents.

b. Current Activities

The Oral Health Program convened a coalition to assist the program in development of oral health policy, identify strategies to increase access to dental care for underserved populations,

and develop an oral health surveillance system and comprehensive state oral health plan.

The Oral Health Program hired a health program manager to staff the coalition, track community water fluoridation reporting to promote "optimal" fluoridation, and assist the Dental Officer in development of educational materials to support the program. These are infrastructure-building services.

The program has hired a contractor to conduct an oral health screening survey (Basic Screening Survey) of third-grade children from a sample of 50 elementary schools in the fall of 2004. This project will provide statewide and regional baselines for oral health indicators including caries experience, untreated caries and dental sealant utilization. The project hopes to identify a process using a smaller sample size for annual tracking of these indicators. These activities are population-based services.

The program worked with the State Primary Care Office to provide an external clinic rotation of a pediatric dental resident (Children's Hospital of Wisconsin) to the interior region of the state. It is hoped this will provide future external clinic rotations from this hospital-based pediatric dental residency program and ultimately result in recruitment of some residents when they complete the residency. These activities are enabling services.

The program hired a contractor to conduct an inventory of fluoridation equipment to identify future repair and replacement needs. The program also worked with the Denali Commission and Alaska Native Tribal Health Consortium to identify a process for application of funding to support fixed and portable dental equipment in renovation and construction of village health clinics.

In FY2004 the grant to provide travel support for pediatric dental teams to serve children enrolled in Medicaid/SCHIP (Denali KidCare) in Southeast Alaska was discontinued. However the project continues and is included in a continuing care agreement between the department and SEARHC.

c. Plan for the Coming Year

The Basic Screening Survey and data analysis will be completed. The program will 1) apply for a HRSA SOHCS grant to conduct an oral health screening of preschool age children (focus on children enrolled in Head Start) and staff to coordinate and support development of school-based/linked dental sealant programs, 2) begin the planning process for development of a comprehensive state oral health plan, 3) conduct an analysis of this indicator in SFY2005 with the Maternal and Child Health Epidemiology Unit Staff for the MCHB Title V - five year needs assessment, and 4) initiate Internet access to Alaska community water fluoridation information for health or dental care providers and the public.

Oral health access questions will be added to the new Pregnancy Risk Assessment Monitoring System (PRAMS) in FY2005.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

The MCH Block Grant continues to fund a position focused on childhood safety and injury prevention. This position is located in the Division of Public Health, Section of Community Health and Emergency Medical Services (CHEMS).

In FY 2003, work continued to focus on conducting workshops that provided training on Child Passenger Safety (CPS) Technical Training. These workshops took place with the Division of Juvenile Services in Juneau and Fairbanks, the hospital on Kodiak Island, and for the staff of the Alaska Native Medical Center (ANMC)/Southcentral Foundation. Southcentral Foundation, the health corporation for the Cook Inlet Tribal Council, operates the largest CPS distribution program in the state. Any native enrollee who attends their training session receives the appropriate childseat or booster.

Work was also done with the SAFE KIDS groups, Office of Boating Safety, Coast Guard Auxiliary, and community service groups like Kiwanis to strengthen the Kids Don't Float (KDF) program to reduce childhood drowning. This national award-winning program was developed by the SAFE KIDS Coalition in Homer.

Staff also provided support to the advisory board for the Alaska Prevention of Fire-Related Injuries project directed toward putting photoelectric fire detectors in mobile homes and to the statewide Walk Your Child to School/Bus Stop project.

Staff participated in piloting Moving Kids Safely for the National Highway Traffic Safety Administration (NHTSA). This two-day certified course designed for childcare providers has now been implemented nationally.

Data provided by Alaska PRAMS and Alaska Trauma Registry show low infant car restraint use and a high rate of motor vehicle related injuries for infants and toddlers by native populations in general and in particular in two rural regions of the state. Staff worked jointly with the Indian Health Services facility to bring the first NHTSA CPS Technician class to the city of Bethel located in the Yukon Kuskokwim Delta. Ten CPS techs from Bethel and surrounding areas completed the training.

All of the activities listed here are infrastructure-building services.

The MCH Epidemiology Unit published data related to Alaska's child unintentional injury mortality rate in the first edition of the Alaska MCH Data Book 2003. The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), published an Alaska MCH Fact Sheet "Infant Car Seat Use in Alaska" Vol 3: No 3, March 2004. This was placed on the MCH Epi website and was also distributed at the National Highway Traffic and Safety Administration Lifesavers Conference in San Diego, CA on March 30, 2004. MCH Epi Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), added a modular question on frequency of infant car seat use as a state-specific question on the new Phase 5 PRAMS survey. The last data published was collected during 1996-1999. These new data will be available for birth years 2004-2008 (approximately).

b. Current Activities

In FY 2004 continued to coordinate the grants awarded to four SAFE KIDS Coalitions and three chapters and taught the Child Passenger Safety Technical training course in a number of communities throughout Alaska. For the first time, this position participated in delivering the Safe Native American Passengers (SNAP) training for transporting children to the staff at the NICU at ANMC. Presentations were also conducted on child passenger safety for underserved communities at the national Life Savers Conference in San Diego on serving underserved communities.

As budget changes within the state have affected the capacity to provide prevention services such as CPS instruction by the Section of Public Health Nursing, other capacity building efforts have been explored. To date this includes working with the State Office of Highway Safety to assist Fairbanks Memorial Hospital to sponsor a CPS inspection program for the Fairbanks

area and with the Southeast Regional Native Health Corporation (SERHC) located in Juneau. In addition, collaboration with community fire fighting services has occurred to meet the increased demand for CPS services. This effort has led to training a number of firefighters in the Anchorage Fire Department as CPS technicians. Other communities will be approached in the future as well.

The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes data related to this indicator easily accessible and available on the MCH Epi website.

All of the activities listed here are infrastructure-building services.

c. Plan for the Coming Year

In FY 2005 administration of the grants to the SAFE KIDS Coalition and chapters will continue as well CPS training across the state and updating the State Injury Prevention Plan. With the Division of Public Health facing decreasing government funding, work will be focused on institutionalizing the Community Passenger Safety training programs in communities throughout Alaska. Plans exist to repeat the SNAP course for child care providers and repeat the two-day Operation Kids programs targeted toward law enforcement personnel. Staff also plans to provide training and child seats to DFYS offices in the major communities as well as support the Kids Don't Float programs and stations throughout Southcentral Alaska. Finally, the Bike Rodeo skills awareness programs conducted in Southcentral Alaska will occur as well as the Walk to School program.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

In 2002, Alaska was third in breastfeeding initiation in the United States, 87.4%, and exceeded the breastfeeding duration at six months Healthy People 2010 indicator, 50.2%. Alaska was awarded a Using Loving Support to Build Breastfeeding Friendly Communities United States Department of Agriculture (USDA), $75,000.00 Food and Nutrition Services (FNS) Grant. An Alaska specific implementation plan in collaboration with the Alaska Breastfeeding Coalition (ABC) and the Alaska WIC Program was developed. A "Breastfeeding Loving Support...It's Tradition!" materials and theatre advertisements campaign were distributed. The ABC expanded to Wasilla-Palmer and Kenai. Lactation Advisory Groups in Nome and Bethel continued to support their communities.

The MCH Epidemiology Unit published data related to breastfeeding in the first edition of the Alaska MCH Data Book 2003. The MCH Epidemiology Unit published and made available on the MCH Epi website an Alaska MCH Fact Sheet "Healthy People 2000: Summary of Alaska's progress in maternal, infant, and child health objectives over the last decade" Vol 3: No 2, February 2004. MCH Epi Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), added a modular question on reasons for stopping breastfeeding as a state-specific question on the new Phase 5 PRAMS survey. The last data collected on this topic was during 1996-1999. These new data will be available for birth years 2004-2008 (approximately).

These activities are infrastructure building services.

b. Current Activities

Alaska WIC is the recipient of $25,000.00 additional USDA FNS funds and $35,000.00 WIC Operational Adjustment (OA) funds to develop, coordinate and implement the Alaska WIC Competent Professional Authority (WIC CPA) Phase III Training: Alaska Breastfeeding Basics: Using Loving Support.

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to breastfeeding in the second edition of the Alaska MCH Data Book - featuring PRAMS data. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes available updated HA2010 breastfeeding initiation and 4 weeks breastfeeding with year 2000 data on the MCH Epi website.

These activities are infrastructure building services.

c. Plan for the Coming Year

Alaska WIC accepted $82,000.00 to conduct Using Loving Support to Manage Peer Counseling Programs. The funds will enable Alaska WIC to begin implementation of an effective and comprehensive statewide breastfeeding peer counseling program.

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to publish an Alaska MCH Fact Sheet on "Breastfeeding in Alaska".

These activities are infrastructure building services.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

The State of Alaska's Universal Newborn Hearing Screening/Early Hearing Detection & Intervention (EHDI) Program was moved from the Division of Public Health, Section of Maternal, Child & Family Health (MCFH) to the Division of Health Care Services, as a result of a Department of Health & Social Services reorganization.

Site visits were made by the EHDI Program Manager and the EHDI Surveillance Manager to communities implementing the screening programs to provide technical assistance and connect providers involved in the EHDI process beginning at the screening facility, through the diagnostic phase, and ending at early intervention. The EHDI Program Manager continued to work with the remaining eight birthing hospitals not implementing newborn hearing screening programs. In an effort to assist facilities with annual birthing rates of less than 50 to begin newborn hearing screening, the EHDI Program purchased five portable hearing screeners and placed them in five communities. (Infrastructure Building, Population-based and Enabling Services)

All written educational materials were developed by April 2003 and disseminated to healthcare providers, parents, early intervention specialists and hospital personnel beginning in May 2004. (Enabling Services)

A database was developed in-house by a MCFH IT staff for tracking and surveillance of newborns, particularly those identified who are at risk for hearing loss or failed their initial screen. In addition, the database will ensure that children receive timely audiological diagnostic evaluation and enrollment into early intervention services as needed. (Infrastructure Building Services)

b. Current Activities

The EHDI Program Manager worked with the remaining eight birthing hospitals not implementing newborn hearing screening programs. As of January 2004, all 23 birthing hospitals in Alaska owned and/or had access to newborn hearing screening equipment and were implementing the screening in their communities. In an effort to reach babies born in birthing centers and home deliveries, the EHDI Program has purchased and placed two portable hearing screeners in two public health centers whose communities have high numbers of babies born outside of the birthing hospitals. (Population-based and Enabling Services)

In addition to the written educational materials, the EHDI Program developed a video for rural Alaskan healthcare providers, termed Community Health Aide/Practitioners (CHA/Ps). The video identifies newborn hearing screening, speech and hearing developmental milestones, high risk factors for late onset and/or progressive hearing loss, and proper protocol for CHA/Ps if a hearing loss is suspected in a child. (Population-based Services) The EHDI Program Manager is working with the CHA/P Program to disseminate the video through teleconference presentations with CHA/Ps, mail outs for continuing medical units, and in-person presentations. Using footage from the video, the EHDI Program developed one radio public service announcement (PSA) and one television PSA. Using the PSAs, the EHDI Program is conducting a statewide media campaign focusing on rural Alaskans stressing the importance of screening newborns at birth for hearing loss. (Infrastructure Building, Population-based and Enabling Services)

The EHDI Program Manager worked with the Alaska Public Health Association in the development of the 2003 Alaska Health Summit to include a Universal Newborn Hearing Screening/Early Hearing Detection & Intervention presentation. The presentation featured an audiologist from the National Center for Hearing Assessment & Management in Utah. (Population-based and Enabling Services)

c. Plan for the Coming Year

The EHDI Program will develop a 12-month calendar to reemphasize messages disseminated during the EHDI media campaign including normal speech and hearing developmental milestones and the importance of newborn hearing screening. (Population-based and Enabling Services)

The EHDI Program Manager and EHDI Surveillance Manager will travel to all communities implementing newborn hearing screening programs not visited in 2004. The EHDI Program Manager will continue to work with hospitals and birthing centers to increase the number of babies born in these facilities that receive hearing screening. In an effort to reach babies born in birthing centers and delivered at home, the EHDI Program will place an additional portable hearing screener in an additional community with a high number of home deliveries at the public health center. (Infrastructure Building and Population-based Services)

As a result of the DHSS reorganization, the EHDI Program no longer had access to IT support to assist with the development and monitoring of the in-house database. Therefore, EHDI Program staff interviewed five commercial database vendors via teleconferences and web presentations. The EHDI Program Surveillance Manager will develop a request for proposal and solicit bids from the five commercial database vendors. The EHDI Program staff will identify a vendor from whom to purchase the EHDI database with a goal of implementing it in all birthing hospitals by the completion of December 2004. (Infrastructure Building Services)

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

The Denali KidCare Outreach Program was administered through the Alaska Division of Public Health between SFY 99 and SFY 03. During that time, the State Department of Health and Social Services was the recipient of the Robert Wood Johnson Covering Kids grant and worked with two pilot projects under the Alaska Native Tribal Health Consortium and the Mat-Su Borough. This Program was extremely successful, and Alaska was the first State to exceed our enrollment goal and expend our Title XXI allocation.

Midway through FY03, it was announced that the Denali Kidcare Outreach program staff positions would be eliminated in the coming year's budget. The focus of the work for the remainder of FY03 was primarily on transitioning materials and training to as many community members as possible on the recruitment and enrollment process. In addition, the Alaska Native Tribal Health Consortium received a Robert Wood Johnson Covering Kids and Families grant during FFY 03; they assumed primary responsibility for outreach during FFY 04. The Covering Kids grant supports development of a statewide coalition and two pilot projects. One project involves modifying renewal notice format and envelopes to test which changes are most effective in increasing the on-time rate of returned renewal forms. Southcentral Foundation the non-profit arm of Cook Inlet Tribal Council is working with the State Divisions of Public Assistance and Health Care Services and the Alaska Native Tribal Health Consortium on this project to improve program processes and efficiencies under a Robert Wood Johnson Process Improvement Collaborative. The Southcentral Foundation has also been testing renewal telephone reminders to determine their effects on the form return rate.

The Alaska Primary Care Association is leading the second project, which involves developing a coalition to increase access to care for immigrants and individuals who speak English as a Second Language. The focus of this project has been on training and the development of culturally appropriate materials to assist Limited English Proficient populations in the application and renewal process.

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), added a modular question on barriers to well-baby checkups as a state-specific question on the new Phase 5 PRAMS survey. These data have never been collected before and will be available for birth years 2004-2008 (approximately).

All these activities are infrastructure building services.

b. Current Activities

Beginning with the FY 2004 application, the Kaiser Family Foundation is the data source for this measure. This Foundation estimated that 13% of Alaska's children were uninsured in FY 01 and 12% in FY 02. When the FY 2004 application was prepared, there was concern that a reduction in the income eligibility level for the Denali KidCare program from 200% to 175% of the federal poverty level beginning in September 2003 would increase the number of uninsured children. The number of children insured under Denali KidCare (Title XXI funding) has declined somewhat during FFY 2004 while the number of children insured under Title XIX funding has increased. It is not clear if this result is due to diminishing family incomes, seasonal employment, an increasing proportion of applications from families who are always eligible under the lower ceiling, or some other cause.

All of the state Denali KidCare Outreach program positions were eliminated at the beginning of SFY 04, and the Alaska Division of Public Assistance was given responsibility for the Outreach Program. Staff from the Division of Public Assistance are actively involved in working with the RWJ Covering Kids and Family grant in furthering outreach and simplifying the renewal process.

c. Plan for the Coming Year

In FFY 05, the State will continue to follow Title XXI State Plan. State outreach efforts will include supporting the Alaska Covering Kids Coalition to ensure that the three goals of the Robert Wood Johnson Covering Kids and Families grant are met. These goals are outreach, program simplification and coordination with other health coverage options or programs.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

The percent of potentially Medicaid-eligible children who received a Medicaid-funded service was 84.0% during FFY 2003. This proportion has been increasing steadily since 1997.

During FY03, the Denali KidCare Outreach Program as part of the Section of Maternal Child, and Family Health in the Division of Public Health made a focused effort to visit private schools, alternative schools, military schools and all public high schools to offer materials and enrollment assistance, and produced media materials that appeal to junior high and high school students. A particular effort was made to enroll students school age and above in the rural and less populated areas of the state. Outreach also focused its message on the importance of a complete well child check even when conducted as a sports or school physical.

The state Department of Health and Social Services also worked with various Tribal health corporations to help them develop capacity for serving the health needs of their beneficiaries. One of the largest Tribal corporations has had a continuing care agreement to enhance their provision of services related to the Early Periodic Screening Diagnosis and Treatment program since 1998. During federal fiscal year 2003, the Office of Program Review in the AK DHSS Commissioner's Office began efforts to encourage other Tribal corporations to consider entering into similar agreements. (Infrastructure building service)

b. Current Activities

As a result of the work to encourage more tribal health corporations to provide well child care, five additional Tribal corporations have now signed continuing care agreements with the State of Alaska DHSS. Under these agreements, the Tribal corporations will assume greater responsibility for providing services related to the Early Periodic Screening Diagnosis and Treatment program in exchange for increased funding. (Infrastructure building service)

c. Plan for the Coming Year

The DHSS Office of Program Review will continue to work with Tribal corporations on the development and implementation of various strategies for increasing their capacity to provide services to their beneficiaries. The greatest impact from these efforts for Medicaid-eligible children will be related to the continuing care agreements. In addition, the Early Periodic Screening Diagnosis and Treatment program will initiate work with private providers to both encourage them to increase the number of well-child exams they conduct and to enrich the quality of care associated with these exams. (Infrastructure building service)

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

The Section of Maternal Child and Family Health continued the pilot project using Medicaid funds for case management of high-risk pregnant teens. The primary goal of this project was to reduce low birth weight births in this population. Due to funding cuts, it was decided that this would be the last year of the pilot, thus efforts focused toward the end of the state fiscal year to transition the teens receiving services to other agencies. Although the project did not demonstrate a reduction in low birth weight, it was successful in engaging the teen mothers to seek regular prenatal care, enroll at WIC centers, and participate in some type of school setting in order to seek completion towards their diploma or GED. These activities were enabling services.

Although the pilot ended after more than 10 years in June of 2003, other efforts continued especially in the area of tobacco cessation with the Tobacco Prevention Program. This work focused on developing a public information campaign, health care provider training, and systems of referral for tobacco cessation programs. In addition, staff from the Perinatal and Children's Health Unit, MCFH participated in collaboration with the March of Dimes to work on their Prematurity Prevention national campaign. These activities fall in the infrastructure-building service section of the core public health pyramid.

The MCH Epidemiology Unit published data related to low and very low birth weight prevalence in the first edition of the Alaska MCH Data Book 2003. The MCH Epidemiology Unit published and made available on the MCH Epi website an Alaska MCH Fact Sheet that addressed this measure: "Healthy People 2000: Summary of Alaska's progress in maternal, infant, and child health objectives over the last decade" Vol 3: No 2, February 2004. These are infrastructure-building services.

b. Current Activities

With the dismantling of the Section of Maternal, Child and Family Health, work in this area has focused on collaboration with the March of Dimes on their Prematurity Campaign. The Title V/CSHCN Director sits on the program review, public affairs and campaign steering committees for the March of Dimes. Currently the program services committee for the March of Dimes is evaluating program proposals focused on reducing the number of premature births. Once a decision is reached, efforts to collaborate and support the proposal and its stakeholders with some funds, staff expertise and/or technical assistance from the Division of Health Care Services, Children's Screening Services will be considered. These activities are infrastructure-building services.

In addition, with the changes in eligibility for pregnant women's Medicaid, ongoing monitoring will be important in order to evaluate the numbers of women who seek out prenatal care late in their pregnancy or deliver with no prenatal care due to their ineligibility for Medicaid coverage. In addition, changes in the percent of very low birth weights among all births will be important to track.

The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes available detailed low birth weight prevalence tables on the MCH Epi website.
These are also infrastructure-building services.

WIC continues to place emphasis on outreach and collaboration with referral agencies/entities in the state and community levels in an effort to address the problem of low birthweight in Alaska. Nutrition education information and referral to prenatal care services are provided to help ensure positive birth outcomes and reduce the incidence of low birth weight among infants born to women who were enrolled in the WIC Program during their pregnancy. These activities are enabling services.

c. Plan for the Coming Year

Staff from the Division of Health Care Services, Children's Screening Services unit will participate as they are able in the community efforts with statewide obstetrical health care providers, professional medical and nursing organizations, and the local March of Dimes chapter focused on reducing the percentage of low birth weights. Ongoing collaboration with WIC will also occur as they anticipate serving 23,200 pregnant women in FY05.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

The Division of Alcohol and Drug Abuse provided funding to rural communities to prevent suicide and increase wellness. Ongoing staff training was provided and regional suicide prevention wellness conferences were held. The Adolescent Health Coordinator continued to work in the promotion of the Developmental Assets framework to address adolescent risk behaviors and provide technical assistance to agencies providing suicide prevention activities as requested.

The MCH Epidemiology Unit published teen suicide data in the first edition of the Alaska MCH Data Book 2003.

These activities are infrastructure-building services.

b. Current Activities

The Division of Mental Health and the Division of Alcohol and Drug Abuse were reorganized into the Division of Behavioral Health. A considerable amount of time was devoted to planning and integrating the functions of each Division into the new one. The former Adolescent Health Coordinator was hired as the Resiliency Youth Development Specialist to provide assistance to the Division and its grantees as they integrate concepts of resiliency into their services. The Division of Behavioral Health continued with funding to rural communities to prevent suicide and increase wellness. Ongoing staff training is provided and regional suicide prevention wellness conferences were held. The suicide crisis line is in place. The Suicide Prevention Council underwent significant staffing changes and reorganization. A Suicide Prevention Plan is under development. Gate Keeper training is being developed. A plan for conducting psychological autopsies is in place.

The MCH Epidemiology Unit published and made available on the MCH EPI website an Alaska MCH Fact Sheet that addressed this measure: "Risk Behaviors Among Alaskan Youth Decrease" Vol. 3, No. 4, May 2004. The MCH Epidemiology Unit will publish an Alaska MCH Fact Sheet that addresses teen suicide trends and suicidal thoughts.

These activities are all infrastructure-building services.

c. Plan for the Coming Year

The Division of Behavioral Health will continue with its efforts to integrate the services of the previous divisions. Funding will be continued in rural communities to prevent suicide and increase wellness. Ongoing staff training and regional suicide prevention wellness conferences are planned and the suicide crisis line will continue. The Suicide Prevention Council will complete its Suicide Prevention Plan. Both the "Gate-Keeper" trainings and psychological follow-back autopsies will be underway. These activities are infrastructure building services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

Data for FY02 shows a slight increase in the percentage of low birth weight infants delivered at facilities for high-risk deliveries and neonates (from 71.2 to 71.4). This change is not statistically significant, but the percentage does exceed the national performance target of 65%.

Significant challenges exist in transporting women in labor with high risk and/or low birth weight infants from rural or smaller urban communities to Anchorage where the state's only high risk Perinatal unit and Level III nursery are located. This issue has necessitated focused efforts in recent years to improve early identification of high-risk mothers and transfer of them to tertiary care for ongoing care and monitoring. In FFY01-02, state MCH staff worked with members of the All Alaska Pediatric Partnership to identify access issues and barriers around transferring high-risk women to the appropriate level of care. This led to the successful recruitment of a perinatologist for the native health system, which increased the state's total number of perinatologists to three. Since his arrival, the two private perinatologists share call and cover the overall maternal transport system for the state provided and managed by Providence Alaska Medical Center, the state's regional perinatal and neonatal center. This has led to an overall increase in access to high risk obstetric care for native women in particular and allows for the possibility of earlier transfer from rural providers to the perinatologist now located at the tribal health facility in Anchorage when potential obstetric problems have been identified. The activities fall into the infrastructure-building level of the pyramid.

Last year, it was recognized an additional perinatologist would be needed to handle the volume of patients who are native as well as build in the capacity to serve military enlisted and dependents who have high-risk pregnancies. With this increased capacity, the need to transport the military patients to Seattle could be possibly avoided.

b. Current Activities

State staff continued to participate in the sub-specialty identification and recruitment committee of the All Alaska Pediatric Partnership. The Division of Health Care Services provided Medicaid claims data as part of this assessment phase to determine what births were occurring where. This information combined with data from the Alaska Neonatologists and Vital Statistics, once collected will assist in targeting areas of the state that have low birth weight and very low birth weight deliveries. The Title V/CSHCN director is also serving on the March of Dimes program services committee. The committee is currently evaluating proposals that identify programs or educational efforts that would work towards further reducing preterm deliveries as well as assuring mothers with a low birth weight pregnancy, deliver in a high-risk perinatal center. These are examples of infrastructure-building activities.

Efforts by the Alaska Native Tribal Health consortium to recruit a second perinatologist have not been successful to date. They plan to continue to actively recruit over this next year.

c. Plan for the Coming Year

The TitleV/CSHCN director will continue to work closely with the program services committee of the March of Dimes in the implementation of the project chosen to support that focuses on strategies to reduce the number of premature births. The Division of Health Care services will continue to work closely with the Division of Public Health, Section of Epidemiology, MCH Epi and Vital Statistics section on the analysis of data to provide a more targeted approach to earlier identification, transfer and treatment for women at risk for a preterm/low birth weight

baby.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

In fiscal year FY03, the revised Healthy Baby and Newborn Diary was updated, printed and distributed to prenatal care providers throughout Alaska. Demand ran so high, that the printing of 15,000 copies lasted only into the first quarter of FY04. The handbook contains much of the same information produced by MCHB, but also has many Alaska specific resources and information more relevant to Alaskan families. Copies are free to the public. This is an infrastructure-building activity

Work with the Alaska Native Tribal Health Consortium RWJ Covering Kids and Pregnant Women grant began in FY03 with a focus to enroll as many people as possible by August 31, 2003 prior to when the implementation of the new lower eligibility guidelines went into effect (September 1, 2003). State staff participates on the steering committee for this grant.

The MCH Epidemiology Unit published data related to prenatal care data in the first edition of the Alaska MCH Data Book 2003. The MCH Epidemiology Unit published and made available on the MCH Epi website an Alaska MCH Fact Sheet: "Healthy People 2000: Summary of Alaska's progress in maternal, infant, and child health objectives over the last decade" Vol 3: No 2, February 2004. This is an infrastructure-building service.

b. Current Activities

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to prenatal care in the second edition of the Alaska MCH Data Book - featuring PRAMS data. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes available prenatal care data on the MCH Epi website.

Data collected by the Title XXI coordinator has not yet been analyzed to examine the overall impact to pregnant women as a result of the lower eligibility guidelines. The numbers of women and children qualifying for Title XXI have decreased while the numbers of families qualifying for Title XIX Medicaid have increased. Trending will continue for this fiscal year to measure the impact. These are infrastructure-building services.

c. Plan for the Coming Year

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to analyze the predictive value of birth certificate information to assess prenatal care. The MCH Epidemiology Unit, MCH Indicator Surveillance Project, plans to publish an Alaska MCH Fact Sheet on trends in prenatal care by race.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Expand newborn testing using tandem mass spectrometry to test for over 30 conditions that could adversely affect an infant's health and mental growth.	☐	☐	☑	☐
2. Continue education and communication with providers who have high refusal rates.	☐	☐	☐	☑
3. Develop a brochure for prenatal clients and distribute through healthcare offices across Alaska.	☐	☐	☑	☐
4. Provide community education through radio talk shows and presentations at university medical and laboratory assistant's classes.	☐	☐	☑	☐
5. Streamline follow-up tracking and referrals to expedite diagnostic testing for newborns screening positive.	☐	☐	☑	☐
6. Refer infants identified with PKU, MCAD, and CAH to state-sponsored Genetics and/or Metabolic Clinics.	☑	☐	☐	☐
7. Provide information on reportable conditions to the Alaska Birth Defects Registry.	☐	☐	☐	☑
8. Convene the newborn Metabolic Screening advisory committee on a quarterly basis to develop policies and provide education.	☐	☐	☐	☑
9. In collaboration with specialists from Oregon Public Health Labs, assure referrals to local subspecialist in Hematology and Endocrinology.	☐	☐	☑	☐
10. Continue education and monitoring of specimen quality to assure a high level of screening is conducted.	☐	☐	☐	☑

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Provide information to families about their genetic disorder, testing and recurrent risk to future pregnancies.	☑	☐	☐	☐
2. Provide families a medical report summarizing their genetics or specialty clinic visit.	☑	☐	☐	☐
3. Provide families information about national and local support groups, local parent contacts, pen-pals, and internet chat rooms.	☑	☐	☐	☐
4. Refer patients to other clinics, agencies, or programs as appropriate for their condition.	☐	☑	☐	☐
5. Solicit feedback from parents who attend state-sponsored clinics to determine their level of satisfaction.	☐	☐	☐	☑
6. Provide information packets on cleft lip/palate for distribution to parents of newborns with facial clefts.	☑	☐	☐	☐
7. Annual self-assessment of EI/ILPs includes family satisfaction suveys.	☐	☐	☐	☑
8. Provide grant funding for parent navigation services at Cleft Lip/Palate				

clinics.	☑	☐	☐	☐
9. Survey families annually concerning their level of satisfaction with parent navigation services for Cleft Lip/Palate and what might be improved.	☐	☐	☐	☑
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Gather and track medical home information for every child accessing state-sponsored CSHCN services.	☐	☐	☐	☑
2. Use MCH block grant funds and program receipts to support genetics and specialty clinics for CSHCN.	☑	☐	☐	☐
3. Assist patients in obtaining a medical home if they do not have one.	☑	☐	☐	☐
4. Furnish reports summarizing genetics and specialty clinics visits to families and to their primary care providers.	☐	☑	☐	☑
5. Supply Paper Trails notebooks to families who attend Cleft Lip/Palate Clinics as needed to assist families in managing medical records.	☐	☑	☐	☑
6. Provide continuing education about neurodevelopmental topics to staff at rural public health centers and to private providers.	☐	☐	☐	☑
7. Assure linkages to medical home with newly identified newborns who screen patients for a possible metabolic disorder.	☐	☐	☑	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Collect and track insurance information for all children accessing state-sponsored CSHCN Services.	☐	☐	☐	☑
2. Contract with ANTHC to provide IHS funds as payer of last resort for specialty clinics services.	☑	☐	☐	☐
3. Provide genetics and specialty clinics services regardless of inability to pay.	☑	☑	☐	☐
4. Collaborate with Division of Senior and Disability Services to streamline processes for CSHCN to apply for waivered services (Tefra, CCMC, DSMK).	☐	☑	☑	☐
5. Participate with Division staff assigned to work with ANTHC on the RWJ grant in identifying children who might qualify for Denali KidCare or Family Medicaid.	☐	☑	☐	☑
6.	☐	☐	☐	☐
7.				

	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Continue contracts to deliver genetics and specialty clinics statewide.	☑	☐	☐	☑
2. Hold state-sponsored clinics in public health centers and work with PHNs at the community level to identify and provide services to families and individuals.	☑	☑	☐	☐
3. Geneticists and other specialty providers provide information, medical consultations, and technical assistance to local health providers.	☐	☐	☑	☐
4. Assure culturally appropriate services by holding some clinics at Alaska Native medical care facilities.	☐	☐	☐	☑
5. Provide professional medically-trained interpreters to translate the genetics session for non-English speaking families.	☐	☑	☐	☐
6. Provide information packets about genetics conditions in other languages.	☐	☑	☐	☐
7. Continue collaboration and work with the All Alaska Pediatric Partnerhsip to identify gaps in access to pediatric specialty services and support recruitment efforts.	☐	☐	☐	☑
8. Expand service delivery of metabolic clinics to areas with identified capacity needs.	☑	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Seek opportunities for the early intervention services staff and the Title V/Director of CSHCN to collaborate.	☐	☐	☐	☑
2. Participate in Part C Continuous Improvement Monitoring Process with secondary transition focus.	☐	☐	☐	☑
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐

9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Collaborate with the program for Women, Infant and Child Nutrition (WIC) regarding a review of immunization records for a key immunization indicator (DTAP).	☐	☐	☐	☑
2. Offer technical assistance to the new Immunization coordinator in initializing the Anchorage Immunization Partnership.	☑	☐	☐	☐
3. Revise the Healthy Mom/Healthy Baby Diary to reflect the new Immunization schedule and the recommended use of Redimix (trivalent vaccine).	☐	☐	☐	☑
4. Assist Healthy Families home visitation in validating vaccinations and reaching the goal of full immunization by age two.	☐	☐	☑	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Write an MCH Fact Sheet on Alaska's teen birth rate and sexual behaviors among Alaskan high school students.	☐	☐	☐	☑
2. Create a dynamic data web page that makes data related to this indicator easily accessible and available on the MCH Epi website.	☐	☐	☐	☑
3. Promote Youth Developmental Assets; print and distribute Alaska asset books.	☐	☐	☑	☑
4. Pay for Family Planning Services, including education, and pay for contraceptives.	☑	☑	☐	☐
5. Administer Abstinence Education grant.	☐	☑	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Collect dental access data through Medicaid, PRAMS, BRFSS, YRBS and BSS surveys.	☐	☐	☐	☑
2. Support and promote community water fluoridation.	☐	☐	☐	☑
3. Identify funding to support a statewide dental sealant coordinator.	☐	☐	☑	☐
4. Collaborate with 330 funded Community Health Centers to establish a dental sealant program.	☐	☐	☑	☐
5. Establish an oral health coalition to build a support base for the oral health program and oral health issues.	☐	☐	☐	☑
6. Support coalition activities and the development of a state oral health plan.	☐	☐	☐	☑
7. Conduct and analyze a Basic Screening Survey of third grade and preschool children for statewide data.	☐	☐	☐	☑
8. Collaborate with Tribal programs including Head Start and Environmental Health to support dental access, education, sealant application and water fluoridation.	☐	☐	☐	☑
9. Maintain program web site for dental access, oral health information and coalition activity.	☐	☐	☐	☑
10. Support development of tribal community dental aide/practitioner program.	☐	☐	☐	☑

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Fund a position focused on childhood safety and injury prevention.	☐	☐	☑	☑
2. Create a dynamic MCH/Epi data web page that makes data easily accessible and available.	☐	☐	☐	☑
3. Expand the Child Passenger Safety technical training to be delivered at other community agencies such as firehouses.	☐	☑	☐	☐
4. Expand the delivery of the culturally relevant SNAP course to child care providers in additional locations.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				

1. Develop, coordinate and implement the Alaska WIC Competent Professional Authority (WIC CPA) Phase III Training: Alaska Breastfeeding Basics: Using Loving Support.	☐	☐	☐	☑
2. Provide counseling, education materials and breast pumps through WIC.	☐	☑	☐	☑
3. Continue expansion of the Lactation Advisory Groups in other smaller communities in Alaska.	☐	☐	☑	☐
4. Continue data collection and monitoring through PRAMS.	☐	☐	☐	☑
5. Continue active participation with the Alaska Breastfeeding Coalition.	☐	☐	☑	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Purchase and place two portable hearing screeners in two PH centers whose communities have high numbers of babies born outside of birthing hospitals.	☐	☑	☐	☐
2. Collaborate with Community Health Aides/Practitioners to distribute educational videos.	☐	☑	☑	☑
3. Work with Alaska Public Health Association to develop UNHS/EHDI presentation at 2003 Alaska Health Summit.	☐	☐	☑	☑
4. Travel to communities that have recently implemented UNHS and assure linkages with EI, medical homes and audiology.	☐	☐	☑	☑
5. Contract with commercial database vendor for purchase of EHDI database to be implemented in all birthing hospitals.	☐	☐	☐	☑
6. Repeat public media campaign in January-March 2005 in support of introducing legislation for mandating screening, tracking and reporting.	☐	☐	☑	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Support the Alaska Covering Kids Coalition to assure goals of the Robert Wood Johnson Covering Kids and Families grant are met.	☐	☐	☐	☑
2. Continue to work with the Division of Medical Assistance in their outreach efforts.	☐	☐	☐	☑
3. Continue financial support to the 24-hour/day toll-free Alaska	☐	☐	☐	☑

Information Line which provides referrals to care.				
4. Work with the Office of Rural Health on assuring implementation of pediatric standard of care in the federally qualified public health center.	☐	☐	☑	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Support as needed the work for more tribal health organizations to enter into continuing care agreements.	☐	☐	☐	☑
2. EPSDT will initiate work with private providers to encourage them to increase the number of well-child exams and enrich the quality of care associated with these exams.	☐	☐	☐	☑
3. Send contact letter to pregnant women to inform them of program coverage and eligibility.	☐	☑	☑	☐
4. Target education to foster parents to improve numbers of kids in state custody seen for EPSDT.	☐	☑	☑	☐
5. Assist in the distribution of the new Medicaid beneficiary booklet to all families/head of household receiving Medicaid services.	☐	☐	☑	☐
6. Continue ongoing outreach efforts in the form of reminder letters and simple educational newsletters.	☐	☐	☑	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Collaborate with the March of Dimes on their Prematurity Campaign.	☐	☐	☐	☑
2. Consider supporting program focused on reducing the number of premature births with funds, staff expertise and/or technical assistance.	☐	☐	☐	☑
3. Evaluate the numbers of women who seek out prenatal care late in pregnancy or deliver with no prenatal care due to ineligibility for Medicaid coverage.	☐	☐	☐	☑
4. Track changes in percent of very low birth weights among all births.	☐	☐	☐	☑
5. Create dynamic data web page that makes available detailed low birth weight prevalence tables on the MCH Epi website.	☐	☐	☐	☑

6. Collaborate with Tobacco Prevention Program on cessation education and training activities.	☐	☐	☑	☑
7. Provide nutrition education and supplemental foods through state WIC program.	☐	☑	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Publish an Alaska MCH Fact Sheet that addresses teen suicide trends and suicidal thoughts.	☐	☐	☐	☑
2. Make available on the MCH EPI website an Alaska MCH Fact Sheet that addresses this measure.	☐	☐	☐	☑
3. Suport revision of the Service Recreation Plan and the work of the newly named Resiliency Youth Development Specialist.	☐	☐	☐	☑
4. Support community teaching on suicide prevention as able.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Participate in the sub-specialty identification and recruitment committee for additional perinatology of the All Alaska Pediatric partnership.	☐	☐	☐	☑
2. Title V/CSHCN director will work with March of Dimes program services committee to implement project focusing on strategies to reduce number of premature births.	☐	☐	☐	☑
3. MCH Epi will develop a dynamic data web page that will make available detailed information on low birth weight deliveries.	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Publish trend data, regional data and detailed maternal characteristics related to prenatal care in the second edition of the Alaska MCH Data Book - featuring PRAMS data.	☐	☐	☐	☑
2. Create a dynamic data web page that makes available prenatal care data on the MCH Epi website.	☐	☐	☐	☑
3. Title V/CSHCN Director will work with the March of Dimes program services committee to support the implementation of a project or program focusing on preterm birth prevention. Early PMC is one of the features of this.	☐	☐	☐	☑
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percentage of unintended births*

a. Last Year's Accomplishments

The MCH Epidemiology Unit published data related to unintended pregnancy in the first edition of the Alaska MCH Data Book 2003. The five-year moving average for unintended birth rates by census area for 1996-2000 was published in an addendum of the 2003 MCH Data Book and also posted on the MCH Epi website. As stated in last year's progress report, Alaska added a statement to the PRAMS survey in 2001 to correct potential response bias regarding the "intendedness" of each respondent's current pregnancy. Women giving birth in CY 2001 were the first group to respond to this revised survey; this change may have contributed to the increase seen in this indicator between 2000 and 2001.

Last year, MCFH partnered with Title X to provide funds for family planning services at two service sites to low income women who were not eligible for Medicaid. In addition, statewide public and provider educational campaigns on emergency contraception continued throughout the year. The family planning program continued to collaborate with the breast and cervical cancer screening program (BCHC) to provide low-cost, seamless family planning services to BCHC clients needing contraception. Finally, MCFH staff partnered with other public and community agencies to sponsor the Women's Health Track at the Alaska Public Health Association's annual conference. This conference, as well as several other conferences and training opportunities funded by Title X and the Office on Women's Health, provided updated information for medical providers and public health professionals on women's health issues, including contraception and the need to prevent unintended pregnancies.

b. Current Activities

This year, the Section of MCFH was reorganized and the Women's Health and Family

Planning Program was moved into the Division of Health Care Services (DHCS).

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics related to unintended pregnancy in the second edition of the Alaska MCH Data Book, featuring PRAMS data. PRAMS also will update the five-year moving average for unintended birth rates by census area with 1997-2001 data for this edition of the Data Book. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that will make "unintended pregnancy and live births despite use of birth control" data available on the MCH Epi website.

Staff in the Women's Health and Family Planning Programs collaborated with public and community-based partners on the Alaska Women's Health Partnership to educate the public and medical providers about the need to prevent unintended pregnancies in Alaska. Title V monies currently fund 3 Nurse Practitioner (NP) contracts for family planning services through DHCS; additionally, the Division of Public Health, Section of Nursing receives Title V monies to fund NP salaries at seven public health nursing (PHN) sites in the state. Title X funds (located in DHCS) are used to purchase contraceptives and supplies for the PHN sites and to fund 2 additional family planning clinics in the state. At all Title V and Title X-funded family planning clinics, clinicians help reduce unintended pregnancy in their client population through the promotion of highly effective contraceptive methods including abstinence, and parental involvement in minor clients' family planning decisions. DHCS has offered numerous continuing education opportunities throughout the year on all topics related to reducing unintended pregnancy, including sponsorship of the Women's Health Track of the Alaska Public Health Assn. annual conference (funded with Title X and Office of Women's Health monies).

c. Plan for the Coming Year

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to analyze the predictive value of birth certificate information to assess prenatal care. The MCH Epidemiology Unit, MCH Indicator Surveillance Project, plans to publish an Alaska MCH Fact Sheet on trends in prenatal care by race. DHCS, Women's Health and Family Planning Program staff plans to increase Family Planning Nurse Practitioner contracts from 3 to 4 (adding an additional location). Above DHCS activities and funding will remain the same. Finally, Title X program staff plans to collaborate more closely with Medicaid Services staff on family planning services in an effort to reduce unintended pregnancies in Alaska Medicaid recipients.

State Performance Measure 2: *Rate of substanitatied reports of harm to children per hundred children age 0 to 18*

a. Last Year's Accomplishments

The rate of substantiated child abuse and neglect in Alaska is one of the highest in our nation. The new Office of Children's Services (OCS) joined child protection and permanency, family nutrition, infant learning and Healthy Families to better serve Alaska's vulnerable children, youth and families. Healthy Families Alaska (HFAK) is a voluntary home visiting program that reaches out to women during pregnancy or at the time of birth offering support to parents at risk for child abuse and neglect. The program promotes Never Shake a Baby and Back to Sleep awareness and regular child development screens with appropriate referrals to EI/ILP for additional support. These performance measures are linked to national outcomes for prevention of child abuse and neglect. Alaska is a big state with serious problems of abuse and neglect. The six HFAK grantees provide intensive home visitation services to approximately 427 families in rural, semi- urban, and urban locations throughout the state.

In FY03, the Johns Hopkins University (JHU) study began their two-year interviews of parents to provide data for comparison with baseline interviews on program impact in the areas of maternal mental health, substance use, domestic violence, positive parenting, and child health and development.

The MCH Epidemiology Unit published child, adolescent, and teen mortality (due to intentional injury) data in the first edition of the Alaska MCH Data Book 2003.

b. Current Activities

JHU completed their two-year interviews for study and control groups. The study completion date is June 30, 2004. Process data has been provided to program managers and state staff during the course of the five-year study. Domestic violence, mental health, and substance abuse were identified as the three main stressors leading to poor childhood outcomes. HFAK training enhancements were developed to provide staff with additional training in these areas as well as adding a clinical consultation component to each program to provide training and guidance in these areas. Supervisors received training in reflective supervision to enhance their skills in providing support and direction to staff.

c. Plan for the Coming Year

The focus of OCS is to provide services that support and protect children. HFAK programs will focus on strengthening community partnerships and collaboration, as well as cross training staff in the areas of child protection, family nutrition, and child development. As results from the JHU study become available, program enhancements and training will be developed to better serve families at risk.

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to present "Child Care and Violence in the Home, 2000-2001" at the Tenth Annual Maternal and Child Health Epidemiology (MCH Epi) Conference, Atlanta, Georgia, December 2004.

State Performance Measure 3: *Percentage of women who smoke prenatally*

a. Last Year's Accomplishments

The percentage of women who smoke prenatally was selected as a performance measure because of Alaska's high rate of smoking during pregnancy. In Alaska, according to 2002 PRAMS data, the percentage of women smoking in the third trimester of pregnancy was 14.7% as compared to the Healthy People 2000 goal of 14%. This is a drop of 4% since 1998. Through all of MCFH's activities, but particularly family planning and adolescent health, smoking during pregnancy has been highlighted through awareness materials such as the Healthy Mother/Healthy Baby Diary. The outreach and public education activities directed toward reducing the number of pregnant women who smoke place this performance measure on the population-based services level of the pyramid. PRAMS and WIC will continue to provide data to monitor and track progress. This performance measure is associated with all of the national outcome measures. Additionally, women who smoke during pregnancy are likely to continue smoking after pregnancy putting their infant at increased health risk.

Smoking prenatally in Alaska continues to be an issue, however, some progress does seem to be occurring when compared to the 1998 percentage reported in PRAMS of 18.7%. MCFH has been involved in distributing educational information about the importance of not smoking in pregnancy and has participated with technical assistance and expertise in the media

campaigns designed by the Tobacco Coalition in the state (infrastructure building and population-based services).

The MCH Epidemiology Unit published prenatal smoking data in the first edition of the Alaska MCH Data Book 2003. The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), presented a poster on "Postpartum Smoking Cessation Barriers and Aids For Alaskan Women" at the Ninth Annual MCH Epi Conference, Tempe, Arizona, Dec. 2003. PRAMS contributed prenatal smoking and prenatal smokeless tobacco data for the prenatal and postpartum tobacco use section of the Section of Epidemiology's Tobacco Compendium entitled "Tobacco in the Great Land: A Portrait of Alaska's Leading Cause of Death," February 2004. PRAMS distributed a "road map" of smoking related data available from PRAMS data over the years to the Alaska Native Comprehensive Tobacco Plan Work Group in February 2004. PRAMS also participated in a forum at the Alaska Native Health Board in June 2004 to discuss strategies outlined by the five different tobacco prevention and control groups in the State and determine gaps or other interventions left unidentified. PRAMS pretested new state-specific questions for Phase 5 data collection that will now differentiate between iq'mik use and commercial spit tobacco use in the prenatal period and added a modular question on prenatal ETS exposure as a state-specific question on the new Phase 5 PRAMS survey. These data have never been collected before and will be available for birth years 2004-2008 (approximately).

b. Current Activities

Current activities include the continuation of those listed from last year as well as the dedication of staff time in working with the local March of Dimes chapters on their preterm delivery campaign with a targeted focus of developing smoking cessation classes with local agencies and hospitals as well as the development of support systems for women who are pregnant.

The MCH Epidemiology Unit is publishing trend data, regional data, and detailed maternal characteristics related to prenatal smoking in the second edition of the Alaska MCH Data Book - featuring PRAMS data. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes updated prenatal smoking data easily accessible and available on the MCH Epi website.

c. Plan for the Coming Year

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to publish an Alaska MCH Fact Sheet on "Prenatal Smokeless Tobacco Use in Alaska" and plans to collaborate with CDC personnel on publication "Prenatal Smokeless Tobacco Use among Alaska Native Women in Alaska, 1996-2001". Staff will be working on data with the Maternal-Infant Mortality Review database to facilitate an analysis looking at protective and risk factors for infants who die of Sudden Infant Death Syndrome. In addition, staff will continue active participation with the March of Dimes and community obstetrical providers to provide information and assistance to women to quit smoking prior to pregnancy. These are infrastructure building activities.

State Performance Measure 4: *Percentage of women who drink prenatally*

a. Last Year's Accomplishments

The percentage of women who drink prenatally was selected as a performance measure because of its association with MCFH's priority need for reducing preventable birth defects and

its FAS surveillance project. Performance Measure #4 is placed on the infrastructure building level of the pyramid because of the program activities directly related to the FAS surveillance project.

The MCH Epidemiology Unit published prenatal drinking data in the first edition of the Alaska MCH Data Book 2003 and the Pregnancy Risk Assessment Monitoring System (PRAMS Project) pre-tested a new state-specific question for Phase 5 data collection that will measure the prevalence of women whose prenatal care provider failed to advise them not to drink while pregnant. These data have never been collected before and will be available for birth years 2004-2008 (approximately).

Our FAS surveillance program continues to work closely with the office of FAS to provide surveillance data that can be used to enhance FAS prevention programs. Outside of the Department, the data were used by Native health corporations statewide for use in assessment and program planning (infrastructure building). Staff also worked with the Healthy Families programs to address this issue both prenatally as well as postnatally (enabling service). In this intensive home visitation program, it was noted that women will try to not drink during pregnancy and then start up again with heavy drinking patterns after their child is born.

b. Current Activities

Current activities include those listed for state performance measure #3 as well as the continuation of emphasizing treatment in the families that are part of the Healthy Families program. Ideally enrollment and screening take place during the prenatal period when women are many times the most motivated to improve their health and change their current behaviors. Additional training in the areas of Motivational Interviewing have given the Family Support staff tools to work with families, especially women to support them in obtaining treatment for their substance abuse problems. In addition, MCFH continues to educate legislators and communities about the need for treatment facilities that will enable women who are pregnant and/or have children to be accepted.

The MCH Epidemiology Unit is publishing trend data, regional data, and detailed maternal characteristics related to prenatal drinking in the second edition of the Alaska MCH Data Book - featuring PRAMS data. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes updated prenatal drinking data easily accessible and available on the MCH Epi website.

c. Plan for the Coming Year

Data on prenatal drinking will continue to be used by the FAS Surveillance project as well as the state FAS Coordinator. This data is critical to the FAS Coordinator in continued assessment on the status of prenatal drinking statewide and also in program planning issues. Outside of the Department, the data continues to be requested by Native health corporations statewide for use in assessment and program planning. The MCH Epi Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), plans to link data with the Maternal-Infant Mortality Review database to facilitate an analysis looking at protective and risk factors for infants who die of Sudden Infant Death Syndrome. These are infrastructure-building activities. Staff will continue to work with grantees that deliver the Healthy Families programs to intervene and actively refer women who are drinking especially during their pregnancy, and we will advocate in communities for more treatment facilities for women who have children and need a residential program (enabling service).

State Performance Measure 5: *Percentage of women experiencing physical abuse by*

husbands/partners surrounding prenatal period

a. Last Year's Accomplishments

The percentage of women who experience physical abuse by husbands/partners surrounding the prenatal period is a state performance measure related to Alaska's priority of decreasing family violence. Its placement on the population-based services level of the pyramid reflects the activities conducted. The only population-based data available for Alaska on domestic violence comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data is limited to the population of women who have recently delivered a live-born infant. For state performance measure #5, physical abuse by a husband or partner during the 12 months prior to or during pregnancy - surrounding the prenatal period - is limited to abuse where the mother specifies that her husband/partner abused her.

In FY03, the Alaska Family Violence Prevention Project (AFVPP) conducted a statewide campaign on abuse around the time of pregnancy. A series of materials were developed and distributed statewide to domestic violence shelters, perinatal providers, WIC programs, and other entities providing services to pregnant and postpartum women. Resources included a series of posters on abuse around the time of pregnancy including two targeted to teens who experience abuse and safety and referral cards for mothers experiencing abuse. Three public service announcements (PSAs) were developed for radio and television on abuse and pregnancy in English, Yupik, and Inupiat. These are infrastructure-building activities.

During FY03, the collection and analysis of data was completed from our series of provider surveys on childhood exposure to violence. Survey data for physicians, public health nurses, and nurse practitioners were incorporated into AFVPP curricula on childhood exposure to violence and early brain development. Physician data was presented at the national Domestic Violence and Health Care conference in Boston.

AFVPP continued to offer workshops on domestic violence and childhood exposure to violence. In FY03, training was provided in the following communities: to health care providers in Fairbanks, Anchorage (Providence AK Medical Center), and Homer - child witnesses & pediatric survey; to health care staff and AK Women's Health Partnership steering committee members in Valdez - child witnesses & pediatric survey; for the AK Tribal Injury Prevention Conf. in Anchorage - impact of domestic violence on women & children from an injury prevention perspective; in Cordova & Valdez - health care & public training on DV & effects on children's early brain development; in Anchorage at Elmendorf AFB - training; to health care providers & DV Taskforce in Sitka - child witnesses & pediatric survey; at the IHS/ACF DV Pilot Project meeting & "National Standards Committee" meeting on DV in New Mexico; to health care providers & DV Taskforce in Juneau - child witnesses & pediatric survey, DV reporting; and a statewide teleconference to Public Health Nurses on child witnesses & pediatric survey.

b. Current Activities

During FY04, our curriculum on childhood exposure to violence was expanded to include new data on the biopsychosocial effects of violence on children. Training and technical assistance was provided to the following communities: to health care providers & community members in Juneau on the topic of "Making a Difference: The Impact of Violence on Children from Birth through Adolescence" presentation; to health care providers and community members in Homer on the topic of "Neurophysiological Impact of Family Violence on Adolescents"; a presentation at the AK Health Summit in Anchorage on the effects of violence on children & early brain development; to public health and domestic violence workers at the National Standards Campaign in New Mexico; a workshop on the topic of " Our Children, Our Families, Our Community" in Kotzebue. In addition, "Making a Difference: The Impact of Violence on Children from Birth through Adolescence", a presentation on domestic violence and pregnancy, was offered to health care providers and community leaders in Juneau. The

Project Director also presented to the March of Dimes Program Services Committee on the issue of pregnancy and domestic violence.

The Project Director, Dr. Linda Chamberlain, was the keynote speaker on children exposed to violence for 13 different conferences organized by the California Attorney General's Safe from the Start initiative. She also conducted a series of workshops for 11 child protection regional offices in California.

The project director is serving on an advocacy committee for the March of Dimes committee, and she has also applied for representation on a newly established statewide maternal mortality review committee.

The AFVPP continued to operate a Clearinghouse and Internet website with training and educational resources on domestic violence, AFVPP training manuals & training slides, journal/newsletter articles, AFVPP lending library list (for posters, buttons, magnets, information cards, booklets, and resources on loan), an "Other Links" list of domestic violence-related websites, and AFVPP background. All AFVPP outreach/public education services are provided as part of the mission to support Alaska's women, infants, children and families.

These are all infrastructure-building activities.

c. Plan for the Coming Year

During FY05, the AFVPP will continue an extensive review of literature and cutting-edge research on adolescent brain development. We will develop a curriculum on the critical intersection between adolescent brain development, substance abuse, and exposure to violence. The curricula will be piloted in five Alaska communities with multidisciplinary audiences including health care professionals, public health workers, social workers, law enforcement, and the judicial system.

The AFVPP will expand their curriculum on childhood exposure to violence and early brain development using an evidence-based approach that references all scientific information. A bibliography of references cited in the curriculum will be created and accessible via the AFVPP website. In addition, the AFVPP will develop a brochure on childhood exposure to violence for parents and communities. The brochure will be distributed through the AFVPP Clearinghouse and shelter/advocacy programs throughout Alaska.

The AFVPP will continue to operate a Clearinghouse and Internet website with training and educational resources on domestic violence, AFVPP training manuals & training slides, journal/newsletter articles, AFVPP lending library list (for posters, buttons, magnets, information cards, booklets, and resources on loan), an "Other Links" list of domestic violence-related websites, and AFVPP background. All AFVPP outreach/public education services are provided as part of the mission to support Alaska's women, infants, children and families.

The AFVPP will also continue to build upon its history of collaboration with domestic violence advocates and the medical community through continuing research and updating and expanding the availability of resource/training materials, outreach, and technical assistance.

State Performance Measure 6: *Percent of mothers putting infant down to sleep in the supine position*

a. Last Year's Accomplishments

Data for 2001 indicates an increase from 64.7% to 66.7% of mothers who self report in the PRAMS survey they place their infants in a supine position. This indicates that education during prenatal and childbirth classes as well as community education and hospital discharge education has been effective in communicating the message. Hospitals in FY03 reported their efforts to work on educating their African-American and Alaska Native families about the importance of this measure. Education also focused on ways to safely co-bed, avoidance of co-bedding when the caregivers consume alcohol and avoidance of waterbeds and certain types of bedding and pillows. These are examples of population-based services.

The MCH Epidemiology Unit also published prevalence of mothers putting their infants to sleep on their backs in the first edition of the Alaska MCH Data Book 2003.

Also in fiscal year FY03, the revised Myself/My Baby Health Diary was updated, printed and distributed to prenatal care providers throughout Alaska. Demand ran so high, that the printing of 15,000 copies lasted only into the first quarter of FY04. The handbook contains much of the same information produced by MCHB, but also has many Alaska specific resources and information more relevant to Alaskan families. Examples of specific information in the book include the Back to Sleep campaign and the issues of co-bedding as well as what types of bedding are appropriate for newborns and infants. Copies are free to the public. This is an infrastructure-building activity.

b. Current Activities

The MCH Epidemiology Unit is publishing trend data, regional data and detailed maternal characteristics on the prevalence of mothers putting their infants to sleep on their backs in the second edition of the Alaska MCH Data Book - featuring PRAMS data. The MCH Epidemiology Unit is in the process of creating a dynamic data web page that makes updated prevalence of infant sleep position data easily accessible and available on the MCH Epi website. These are infrastructure-building activities.

Materials on the Back to Sleep Campaign continue to be distributed from the Division of Health Care Services. Anecdotal information from the hospitals indicates this is an issue that still receives a lot of attention in their discharge-teaching curriculum. Facilities caring for native families have also developed their own materials targeting co-bedding and alcohol usage. These are examples of infrastructure-building and population-based activities.

c. Plan for the Coming Year

The Title V/CSHCN director plans to work with MCH EPI staff to examine infant death records to determine if sleeping position has been recorded and continues to be an issue. Educational materials will be reviewed and considered for revision depending on the outcome of the data analysis.

State Performance Measure 7: *Percentage of people who experience intimate partner violence during their lifetime*

a. Last Year's Accomplishments

In FY03, activities conducted by the Alaska Family Violence Prevention Project included co-authorship by the project director of two manuals to promote screening in the health care setting: "Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health" and "Identifying and Responding to Domestic Violence: Consensus Recommendations for Women's Health." The Family Violence Prevention Fund

distributes both of these publications nationally.

Printing of "Arctic Inspirations," a book on creating economic opportunity through self-employment for rural women, was completed with a special grant. The AFVPP distributed the book throughout Alaska to traditional and non-traditional locations including school libraries, community centers, hair salons, and public health nursing. Following a large feature story in the Anchorage Daily News, there were additional requests that continued throughout the year.

The AFVPP continued to operate a Clearinghouse and Internet website with training and educational resources on domestic violence, AFVPP training manuals and training slides, journal/newsletter articles, AFVPP lending library list (for posters, buttons, magnets, information cards, booklets, and resources on loan), an "Other Links" list of domestic violence-related websites, and AFVPP background. All AFVPP outreach/public education services are provided as part of the mission to support Alaska's women, infants, children, and families. All of these activities listed here are infrastructure-building services.

The MCH Epidemiology Unit published data related to Alaska's child immunization rates in the first edition of the Alaska MCH Data Book 2003.

b. Current Activities

The AFVPP provided technical assistance on the National Standards Campaign on Domestic Violence, an initiative involving 15 states that are working collaboratively to improve the healthcare response to domestic violence. As part of this initiative, the "Public Health Toolkit" was created. The curriculum is being distributed nationally at no cost through the national Family Violence Prevention Fund's website. In addition, the AFVPP participated in an educational film on the impact of domestic violence on children and safety planning, developed by the Alaska Network on Domestic Violence and Sexual Assault. The video has been distributed on CD-ROM to domestic violence shelters and programs throughout Alaska.

The AFVPP provided technical assistance to update the national consensus guidelines and recommendations for identifying and screening for domestic violence with adult female patients. The Family Violence Prevention Fund released the updated version in April 2004. The AFVPP continued to provide technical assistance and resources to the 19 domestic violence shelters and advocacy programs throughout Alaska. Technical assistance included helping a women's shelter in Valdez, AK with a grant proposal on trafficking women, providing training curricula for staff to use in their communities, and providing research on health effects of violence on victims and children to assist with training, judicial proceedings, and community education.

The AFVPP has been working on a series of three publications using the health care provider survey data on assessment for childhood exposure to domestic violence.

Additional data analyses were conducted with a review of the literature on the impact of violence on children. The focus is currently physician data, a larger data set that allowed multivariate analyses to examine predictors of screening in the pediatric setting.

The AFVPP published an article on assessment, indicators, and intervention for children exposed to violence that was published in the State of Alaska's publication for emergency medical service providers. A feature article was also published on developing a coordinated response to domestic violence in the public health setting (Health Alert, Volume 9, Winter 2004). Dr. Chamberlain, with two co-authors, is publishing an article about survivors' perspectives on assessing for lifetime exposure to violence in the summer 2004 issue of Health Alert.

The AFVPP continues to operate the AFVPP Clearinghouse and Internet website with training and educational resources on domestic violence.

All of the activities listed in this section are infrastructure-building activities.

c. Plan for the Coming Year

Our Project Director will continue to serve as a steering committee member for the third national conference on domestic violence and health care to be held in October 2004 in Boston, MA. She has been selected as a plenary speaker and is conducting an extensive, comparative review of all of the US Preventive Services Task Force's (USPSTF) recommendations on preventive practices to identify gaps in the national research agenda on domestic violence and the implications of the USPSTF's latest recommendations on screening for domestic violence. This research will be the theme of her plenary session at the conference and will be published as the lead article in the fall 2004 issue of a new on-line journal for family violence. Dr. Chamberlain will also be featured as a keynote speaker and workshop presenter on cutting edge issues in a statewide conference on family violence to be held in October 2004 in Homer, Alaska.

The AFVPP will continue to build upon its history of collaboration with domestic violence advocates and the medical community through continuing research, and updating and expanding the availability of resource/training materials, outreach, and technical assistance. The AFVPP will continue to provide technical and resource assistance, and operate the AFVPP Clearinghouse and Internet website. The AFVPP website will continue to be updated and expanded to provide increased access to domestic violence resources.

The plan activities outlined above are infrastructure-building services.

State Performance Measure 8: *Percentage of people who eat five or more daily servings for fruits and vegetables*

a. Last Year's Accomplishments

The percentage of people who eat five or more daily servings of vegetables and fruits is a state performance measure that highlights the importance of nutrition's role in the development or prevention of four of the top ten leading causes of death in Alaska and the United States. The performance measure is placed on the population-based services level of the pyramid because activities related to the Eat Smart Alaska! Projects are focused on outreach and public education (population-based activities). This performance measure is directly linked to the national outcome measures of neonatal mortality and perinatal mortality.

The Section of Maternal, Child and Family Health's Community Nutritionist position was vacant for over a year (March 2002 - May 2003), so activities to promote 5 A Day for Better Health were limited. The WIC and Senior Farmer's Market programs were in operation during the summer months. Educational materials and recipes were provided at WIC clinics and senior centers. WIC clinics actively promoted the increased consumption of fruits and vegetables throughout the year. These are population-based and enabling activities.

b. Current Activities

The Community Nutritionist position was filled in May 2003 for about eight months. The position is currently vacant and is being moved to Anchorage due to recruitment difficulties and to enhance collaboration with related entities in promoting healthy eating and disease-prevention goals. During the year the activities listed above continued, but on a limited basis.

These activities are population-based and enabling services.

c. Plan for the Coming Year

The WIC and Senior Farmer's Market activities listed above will continue. In addition, the Family and Community Nutritionist will reactivate the Eat Smart Alaska Coalition, a statewide public-private partnership to support the promotion of healthy eating and 5 A Day (infrastructure building). The social marketing campaign for Eat 5 A Day the Alaskan Way will be reinstituted (population-based activity). In partnership with the Child Nutrition Program's Team Nutrition effort, 5 A Day will be promoted in schools statewide (population-based activity). A new Commodity Supplemental Food Program (CSFP) administered by the Nutrition Unit began in May 2003. The Community Nutritionist will develop a CSFP nutrition education program which will promote 5 A Day (population-based activity). This position will also collaborate with a new obesity program in the Division of Public Health, Health Promotion Unit that will promote the increased consumption of fruits and vegetables (infrastructure-building).

State Performance Measure 9: *Prevalence at birth of neural tube defects per 10,000 live births*

a. Last Year's Accomplishments

The Section of Maternal, Child and Family Health accepted a Leadership grant from the March of Dimes to assist in transitioning the Folic Acid campaign into a regular community based message that was part of pre-conception and prenatal care across the state of Alaska. The messages developed were focused on: 1) educating women of childbearing age about the benefits of folic acid in reducing the risk of neural tube defect affected pregnancy; and 2) influencing women of childbearing age to take 400 mcg of folic acid on a daily basis. Information on the importance of folic acid was distributed at public assistance sites, offices where marriage licenses were applied for, bingo halls, Farmer's Markets, bridal shows, the Alaska Women's Run (attended by more than 4,500 women and girls), the state fair grounds and others. Ten-minute phone cards designed to be attractive to teens were created and distributed through Planned Parenthood and other state-sponsored family planning clinics. These are examples of infrastructure-building and population-based activities.

The MCH Epidemiology Unit, Pregnancy Risk Assessment Monitoring System (PRAMS Project), added a modular question on frequency of prenatal/multivitamin use during the last 3 months of pregnancy as a state-specific question on the new Phase 5 PRAMS survey. These data have never been collected before and will add to the current question of frequency of multivitamin use in the month before getting pregnant. These new data will be available for birth years 2004-2008 (approximately). This is an infrastructure-building service.

b. Current Activities

In FY04, state staff transition occurred prior to completing the grant from the March of Dimes. An extension to spend the grant money allowed time to reproduce and update a brochure stressing the importance of a folic acid supplement and its benefits, as well as, sources of food containing folic acid. In addition, distribution of the folic acid "Purple Lady" posters to the tribal community health centers, as well as, the federally qualified community health centers occurred. All nurses in the state received a postcard advertising a web-based self-study with free CEU's available through the March of Dimes. Finally, additional phone cards were obtained for distribution through public health centers offering family planning services. These are infrastructure-building and enabling services.

c. Plan for the Coming Year

The MCH Epidemiology Unit, Alaska Birth Defects Registry (ABDR) is planning to publish a special edition of the Alaska MCH Data Book featuring information on birth defects in Alaska. This will be the first comprehensive summary of birth defects prevalence published in Alaska. The book will provide information on the statewide distribution of major birth defects by birth year groupings, geographic area of residence, race, and other salient characteristics such as maternal age. In preparation for publication of the Birth Defects Edition of the Alaska MCH Data Book, the program will conduct chart reviews for case verification and will estimate the predictive value of a report to the ABDR for prevalent conditions. This comprehensive analysis will provide the first descriptive summary that can effectively be used as a reference for service providers and clinicians, as well as educators and public health organizations on birth defects in Alaska. This is an infrastructure-building service.

A reprinting of the Myself/My Baby Health Diary is planned using MCH Block Grant money in FY05. The diary contains references to the importance of folic acid supplementation and other foods rich in folic acid. The diaries are distributed to public health centers, tribal health clinics, sub-regional facilities, nurse midwives, direct entry midwives, and all obstetrical and family practice providers performing deliveries in Alaska.

State Performance Measure 10: *Percentage of high school youth who feel supported at school*

a. Last Year's Accomplishments

Over time, research has linked youth academic achievement, health outcomes, and school climate. The National Longitudinal Study on Adolescent Health (JAMA, 1997: 278) identified connectedness as a key protective factor correlated with a decrease in youth risk behaviors. After years of planning and negotiation across departments, seven protective factor questions related to youth feeling connected and supported were added to the YRBS in 2003. This was intended as a partial measure of positive health status among adolescents. This activity was an infrastructure-building service.

Through a statewide initiative, the Adolescent Health Coordinator worked with the Association of Alaska School Boards to increase the number of assets (supports and opportunities that lead to connection, support and positive youth outcomes). The completion of the book, "Helping Kids Succeed ~ Alaskan Style" and subsequent, resources, training, and technical assistance provided were part of that effort. This activity was an infrastructure-building service.

b. Current Activities

As noted elsewhere, the Section of Maternal Child and Family Health was eliminated in FY04. While several MCFH functions were integrated into other State divisions, the Adolescent Health Coordinator position was eliminated. This significantly impacted the coordination of adolescent health programs, services, evaluation, data collection/analysis, infrastructure, and system activities. The former Adolescent Health Coordinator was hired by the Division of Behavioral Health as the Resiliency Youth Development Specialist to provide assistance to its grantees as they integrate concepts of resiliency into their services. Former public health/MCFH activities for adolescent health were incorporated as time permitted.

Frequency rates were published for each of the protective factor-based questions on the 2003 YRBS survey. The new MCH Epidemiology Unit for the Section of Epidemiology began to analyze the seven protective factor-based (connectedness) questions with selected youth risk outcomes. The analysis is still underway. This activity is an infrastructure-building service.

The resiliency/youth development specialist worked with the Association of Alaska School Boards to increase the number of assets (supports and opportunities that lead to connection, support and positive youth outcomes) through its seven-year statewide initiative. The book, "Helping Kids Succeed - Alaskan Style" and subsequent resources, training and technical assistance has been part of that effort. Another evaluation instrument of youth support ("Grading Grown-ups - Alaskan Style") was developed, conducted, and analyzed. This activity is an infrastructure-building service.

c. Plan for the Coming Year

The Resiliency Youth Development Specialist from the Division of Behavioral Health will continue to work across State divisions to promote adolescent health, as time permits. She will continue providing leadership and guidance to the statewide Assets Initiative with the Association of Alaska School Boards.

The MCH Epidemiology Unit is conducting an analysis to measure youth connectedness by creating an index variable, based on a composite of seven "connectedness" questions added to the YRBS and correlated with positive youth behaviors. The 2003 YRBS is the first year of available data. Future YRBS surveys will allow us to monitor the prevalence of connectedness over time. There is a large body of research on the value of youth connectedness in predicting healthy behavior. These activities are infrastructure-building services.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percentage of unintended births				
1. MCH Epi Unit is publishing trend data, regional data, and detailed maternal characteristics related to unintended pregnancy in the edition of the Alaska MCH Data Book featuring PRAMS data.	☐	☐	☐	☑
2. Update the five-year moving average for unintended birth rates by census area with 1997-2001 data.	☐	☐	☐	☑
3. Create a dynamic data web page that will make "unintended pregnancy and live births despite use of birth control" data available on the MCI Epi website.	☐	☐	☐	☑
4. Collaborate with public and community-based partners on the Alaska Women's Health Partnership to educate the public and medical providers about the need to prevent unintended pregnancies in Alaska.	☐	☐	☐	☑
5. Use Title V monies to fund three Nurse Practitioner (NP) contracts for family planning services through DHCS.	☐	☑	☐	☐
6. Use Title V monies for Division of Public Health, Section of Nursing to fund NP salaries at seven public health nursing sites in the state.	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Rate of substanitatied reports of harm to children per hundred children age 0 to 18				
1. Complete study on Healthy Families Alaska Program's impact in the areas of maternal mental health, substance use, domestic violence, positive parenting, and child health and development.	☐	☐	☐	☑
2. Develop training enhancements to provide staff with additional training in three main stressors leading to poor childhood outcomes--domestic violence, mental health, and substance abuse.	☐	☑	☐	☐
3. Train supervisors in reflective supervision to enhance skills in providing support and direction to staff.	☐	☑	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percentage of women who smoke prenatally				
1. Publish trend data, regional data, and detailed maternal characteristics related to prenatal smoking in the second edition of the Alaska MCH Data Book - featuring PRAMS data.	☐	☐	☐	☑
2. Create a dynamic data web page that makes updated prenatal smoking data easily accessible and available on the MCH Epi website.	☐	☐	☐	☑
3. Republish and distribute the Myself/My Baby Health Diary.	☐	☑	☐	☑
4. Provide technical assistance and expertise to Tobacco Coalition for media campaign.	☐	☐	☑	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percentage of women who drink prenatally				
1. Publish trend data, regional data, and detailed maternal characteristics related to prenatal smoking in the second edition of the Alaska MCH Data Book - featuring PRAMS data.	☐	☐	☐	☑
2. Create a dynamic data web page that makes updated prenatal drinking				

data easily accessible and available on the MCH Epi website.	☐	☐	☐	☑
3. Continue FAS surveillance project in collaboration with MCH Epi and Division of Behavioral Health.	☐	☐	☐	☑
4. Address issue through Healthy Families Alaska home visiting program.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percentage of women experiencing physical abuse by husbands/partners surrounding prenatal period				
1. Expand curriculum on childhood exposure to violence to include new data on biopsychosocial effects of violence on children.	☐	☐	☐	☑
2. Provide training and technical assistance to communities throughout Alaska.	☐	☐	☑	☐
3. Provide keynote address on children exposed to violence for 13 conferences organized by the California Attorney General's Safe from the Start Initiative.	☐	☐	☐	☑
4. Serve on an advocacy committee for the March of Dimes.	☐	☐	☐	☑
5. Apply for representation on a newly established statewide maternal mortality review committee.	☐	☐	☐	☑
6. Operate a Clearinghouse and Internet website with training and education resources on domestic violence.	☐	☐	☐	☑
7. Participate in new curriculum development on adolescent team development, substance abuse, and exposure to violence.	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of mothers putting infant down to sleep in the supine position				
1. Publish trend data, regional data, and detailed maternal characteristics on the prevalence of mothers putting their infants to sleep on their backs in the second edition of the Alaska MCH Data Book, featuring PRAMS data.	☐	☐	☐	☑
2. Create a dynamic data web page that makes updated prevalence of infant sleep position data easily accessible and available on the MCH Epi website.	☐	☐	☐	☑
3. Update, publish, and distribute the Myself/My Baby Health Diaries which	☐	☐	☑	☐

stress the "Back to Sleep" message.				
4. Participate with the MCH Epi staff in the examination of infant death records and sleeping practice.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percentage of people who experience intimate partner violence during their lifetime				
1. Provide technical assistance on the National Standards Campaign on Domestic Violence, an initiative involving 15 states working collaboratively to improve the healthcare response to domestic violence.	☐	☐	☐	☑
2. Provide technical assistance to update the national consensus guidelines and recommendations for identifying and screening for domestic violence with adult female patients.	☐	☐	☐	☑
3. Develop three publications on the health care provider survey data on assessment for childhood exposure to domestic violence.	☐	☐	☐	☑
4. Conduct data analyses and a review of the literature on the impact of violence on children.	☐	☐	☐	☑
5. Publish an article on assessment, indicators, and intervention for children exposed to violence.	☐	☐	☐	☑
6. Continue to operate the AFVPP Clearinghouse and Internet website with training and educational resources on domestic violence.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percentage of people who eat five or more daily servings for fruits and vegetables				
1. Develop and distribute educational materials and recipes.	☐	☐	☑	☑
2. Promote 5 A Day through WIC clinic activities and counseling.	☐	☑	☐	☐
3.	☐	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐

8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Prevalence at birth of neural tube defects per 10,000 live births				
1. Reproduce and update brochure stressing importance of folic acid supplement, its benefits, and sources of food containing folic acid.	☐	☐	☐	☑
2. Distribute folic acid "Purple Lady" posters to tribal community health centers and federally qualified community health centers.	☐	☐	☐	☑
3. Distribute postcard to all nurses in state advertising web-based self-study with free CEUs available through March of Dimes.	☐	☐	☐	☑
4. Obtain additional phone cards for distribution through public health centers offering family planning services.	☐	☑	☐	☑
5. MCH Epi will publish a special edition featuring information on birth defects in Alaska.	☐	☐	☐	☑
6. Update, print and distribute the Myself/My Baby Health Diary which stresses folic acid supplementation and the reasons why.	☐	☐	☑	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Percentage of high school youth who feel supported at school				
1. Incorporate former public health/MCFH activities for adolescent health in new position in the Division of Behavior Health as time permits.	☐	☐	☐	☑
2. Publish frequency rates for each of the protective factor-based questions on the 2003 YRBS survey.	☐	☐	☐	☑
3. New MCH Epi Unit for the Section of Epi began analyzing the 7 protective factor-based (connectedness) questions with selected youth risk outcomes.	☐	☐	☐	☑
4. Resiliency-youth development specialist worked with Association of Alaska School Boards to increase number of assets (supports & opportunities leading to connection, support and positive youth outcomes) through 7-year statewide initiative.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐

10.				

E. OTHER PROGRAM ACTIVITIES

Oral Health: Expanding adult dental coverage through Medicaid is being discussed by the state Dental Officer, the Dept. of Health & Social Services, & the AK Mental Health Trust. The Oral Health Program contracted with a statewide non-profit health organization to provide professional collaboration & production of a learning center exhibit on oral health--"Smile Alaska"--which is available statewide for use at community & organizational health events.

Nutrition Surveillance: AK Family Nutrition Services began working with the CDC to reinstate our participation on the Pediatrics Nutrition Surveillance System (PedNSS). Internally, with OA funds, work has begun to create Nutrition Surveillance Reports based on the AK WIC data. WIC Paraprofessionals & Professionals will receive training support & continuing education through a Reimbursable Services Agreement (RSA) with the University of Alaska Anchorage, Community & Technical College, Culinary Arts, Hospitality, Dietetics & Nutrition Department.

Early Hearing Detection & Intervention: EHDI Program Manager was asked to participate in an interview with the National Center for Cultural Competence (NCCC) to discuss materials developed for all Alaskans, with particular focus on those developed for Alaska Natives, specifically the EHDI video. Information gathered during the video will be dispersed nationally by the NCCC. The EHDI Program received awards for educational materials developed including: 1) 1st Place in the Marketing Division for the written educational materials from AK Public Relations Society, 2) 1st Place for the video in Medical/Health Education Division from the Telly Awards, 3) 1st Place for the Written Materials Division from AK Press Women, 4) 1st Place for the video in the Media Division from AK Press Women, and 5) the Sizzle Award at the EHDI National Conference.

State staff has provided leadership on the Data Committee for the CDC EHDI National Goals Committee. This committee has been looking at the data elements reportable to the CDC to differentiate minimum, core, & enhanced information. The committee was further divided into subcommittees to look at each goal & determine which data elements would define that goal. A state staff member headed the subcommittee reviewing goal number one. Information was submitted which will be used by a core group who will make the final determination of the minimum data elements. Future direction for this group includes looking at databases, what works best, & looking at logic models for data collection.

Domestic Violence & Sexual Assault: The AK Council on Domestic Violence & Sexual Assault (ACDVSA), State of AK, Division of Public Safety, is currently developing an online Internet data collection system to collect monthly data on families seeking services at each domestic violence shelter. The ACDVSA reported that, during FY03, there were 7653 total incidents reported; 41.33% of those were committed by an intimate partner. We anticipate publishing our physician data on assessment for domestic violence in the pediatric setting in a major pediatric journal.

Women's Comprehensive Care Improvement: Through a HRSA grant, HCS has developed a comprehensive integrated model for women's health care that addresses many issues women face including unintended pregnancy, mental health, domestic violence, & physical health issues. HCS is partnering with a community health clinic in Anchorage, using the quality improvement model, to create a more responsive, comprehensive service that meets the woman's needs. This model is being implemented at three other community health clinics in Alaska.

Breast & Cervical Health Check (BCHC): Alaska's Breast & Cervical Cancer Early Detection Program: BCHC has been administered by MCFH (now HCS) since 1999, although the State has been funded to provide services since 1995. Since 1995, BCHC has screened 20,000 women statewide with a goal of 4,500 annually. BCHC's target population includes medically underserved women aged 18-64, with an emphasis on those of racial/ethnic minority status, & those aged 50-64. Through a state expansion

of Medicaid benefits in 2001, women diagnosed with breast or cervical cancer through BCHC can access treatment funds. BCHC & Native Health Corporation grantees in Alaska have developed a comprehensive model for delivery of services statewide.

Newborn Metabolic Screening (NMS): State staff continues to participate on both the Education & Steering committees for the FELSI grant project. This HRSA grant's goal is to examine the financial, ethical, legal, & social issues regarding expanded newborn screening using tandem mass spectrometry. The NMS Manager has helped develop educational materials, review parent & provider documents, & arrange for focus groups. This committee has established a website at www.newbornscreening.info where both parents & providers can find information on conditions detected through tandem mass spectrometry screening & has analyzed data collected from focus groups & surveys. It is hoped to have all materials finished & available online by the end of this year.

Anemia Intervention & Treatment Project: MCH is conducting a controlled, randomized trial of triple therapy for Helicobacter pylori infection to treat iron deficiency anemia among children in Southwestern AK. This is a collaborative study among the AK Division of Public Health, CDC, Bristol Bay & Yukon-Kuskokwim Health Corporations, & Emory University. We screened 700 children (essentially the entire 7-11 year old population of 10 Southwestern AK villages), identified 230 with H. pylori infection & iron deficiency, completed two rounds of therapy, & three rounds of follow-up evaluation. Preliminary data indicate that H. pylori eradication had a positive impact on iron status & anemia.

Medical Epidemiology: During the past two years, medical epidemiologist completed studies on: incidence of infant physical abuse in AK; asthma prevlance; vitamin D levels among healthy children 6-24 months of age attending WIC clinics in AK; infants born with trisomies 13 & 18; neonatal sepsis & pneumonia mortality; yearly analysis of Maternal-Infant Mortality Review (MIMR) data for 2002; an investigation of a large outbreak of Echovirus meningitis among children attending an overnight camp. Additionally, he has collaborated with the Healthy Families Alaska study, a randomized evaluation of home visitation for new mothers to prevent child abuse and neglect. Most studies written up for journal publication.

F. TECHNICAL ASSISTANCE

/2005/Technical assistance needs during the coming year concern the ongoing challenge and opportunity to integrate MCH programs with Medicaid and how best to utilize Medicaid funding. The reorganization was effective July 1, 2003 and affected most Divisions within Department of Health and Social Services. Programs that originally resided in the Section of Maternal, Child and Family Health were distributed to four different divisions within the Department resulting in challenges and opportunities in an effort to continue ongoing collaboration. Several core services and programs were blended with the state's Medicaid Division into the new Division of Health Care Services. These MCH programs include Breast and Cervical Cancer Screening, Family Planning, Newborn Hearing Screening, Newborn Metabolic Screening, Oral Health, Pediatric Specialty Clinics, Genetics and Birth Defects Clinics, and EPSDT. Staff have worked dilligently to integrate into the work done by the remaining Medicaid staff, but could benefit from other state's experiences //2005//.

V. BUDGET NARRATIVE

A. EXPENDITURES

/2005/Expenditures for FY03 increased slightly as a result of Medicaid dollars that were provided through an intergovernmental transfer in support of the EPSDT program and the SCHIP outreach program and its ongoing expansion efforts. Otherwise the proportion spent on population groups and levels of the pyramid stayed relatively constant from prior years spending.

Projection population groups and levels of the pyramid will become increasingly difficult because of the inability to track actual expenditures accurately in all three divisions. Staff will continue to work with the Finance staff to develop a system which allows for tracking of the Block Grant in an appropriate manner.

In addition, the accountant who tracked expenditures for several years and the Title V Director who did the budget projections are both leaving state service in October of 2004. As a result, there may be challenges in reporting budget numbers in the coming year. //2005//

B. BUDGET

Forms 2-5 are included in the application. For FY05, children's preventative and primary care comprise 30% of the federal allocation. Children with Special Health Care needs reflect 33% of the federal allocation and include services such as specialty and genetics clinics and parent navigation (family care coordination). Administrative costs include salaries and travel for staff to support the Title V Program and are 10% of the Block Grant allocation.

The budget outlined for FY05 is an attempt to estimate what the spending approval will be. The FY05 budget contains funding for salaries, limited travel for staff, contracts for health and related services to women, children and families, supplies for the newborn screening program, medical supplies for Public Health Nurses, contract dollars to support the completion of the MCH five year needs assessment, and dollars for educational materials for the populations served.

Block grant funds will be distributed to three different divisions. Two of the divisions have yet to develop a methodology to track expenditures by population group or by levels of the pyramid. Staff from the Division of Health Care Services plan to work with the other division finance staff to develop this process at the start of the state fiscal year 05. As a result of these accounting practices not yet in place this fiscal year, accurate reporting for the FY06 application for the state-federal partnership will be challenging.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.